

Compensation of Physicians in Ontario

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Compensation of Physicians in Ontario, Canada

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1 The Health Insurance System in Ontario

1.1 Historical Development of the Health Insurance System

In Canada, provision of health and hospital services is clearly under the constitutional jurisdiction of provincial governments; thus, the national Medicare system is composed of ten distinct, though similar, provincial health insurance programs. The health insurance system in Ontario is administered provincially through the Ontario Health Insurance Plan, known by its acronym - OHIP.

The OHIP program forms part of a national health insurance scheme that developed over a period of decades as a result of major initiatives by the federal government. The thrust of these initiatives has been to provide financial incentives to the provinces to undertake achievement of federally-defined program objectives.¹

In 1948, under the National Health Grant Program, grants were provided for hospital construction, health surveys, professional training, research and for selected programs, such as, tuberculosis control. In response to these grants, there was extensive hospital construction and a rapid increase in hospital utilization as measured by patient days per capita.² By the mid nineteen fifties, hospitals, especially smaller ones and those in rural areas across Canada, were facing an acute crisis with respect to financing because less than 40 per cent of the population had hospital insurance, and much of it was not comprehensive.³

In April, 1957, the federal government passed the Hospital Insurance and Diagnostic Services Act establishing a universal hospital insurance program providing comprehensive coverage for in-patient and out-patient services and for related diagnostic services. The federal government would share the cost of this insurance with participating provinces by a contribution of roughly 50 per cent. Five provinces joined the program which began operation on July 1, 1958, and Ontario joined on January 1, 1959, when a Commission was established to administer Ontario Hospital Insurance.

If the federal and provincial governments across Canada eagerly cooperated in coming to the rescue of the financially-troubled, community-sponsored, non-profit hospitals while the insurance industry and the hospital and medical associations remained benignly on the sidelines, the coming into being of medical insurance was more eventful. Even before a Royal Commission on health services in 1964 recommended the setting up of a shared-cost medical insurance program that would parallel the hospital insurance program, one province, Saskatchewan, introduced a universal comprehensive medical scheme on July 1, 1962. This was done over the strenuous objections of the medical profession and there was, as a result, a bitter doctors' strike⁴ that was not resolved for 23 days.

In Ontario, at this time, the private insurance industry joined the medical profession in urging that government insurance, rather than being universal, should confine itself to supplementing existing insurance by enabling the poor and those at high risk to obtain coverage. Nevertheless, the Medical Care Act, which became law in Canada in December, 1966, established shared-cost medical insurance based explicitly

on the principles that were implicit in the hospital insurance program, namely:

- 1) Comprehensive coverage for all medically-necessary services
- 2) Universal coverage on uniform terms and conditions
- 3) Portability
- 4) Public administration

At first, Ontario did not participate in the national medical insurance scheme, having chosen instead to set up, in 1966, a voluntary scheme known as the Ontario Medical Services Insurance Plan through which the indigent and those at high risk could obtain comprehensive insurance coverage through a three-tier premium rate structure based on family composition, and premium assistance based on income. In addition, over 200 private insurance plans, offering a variety of not always comprehensive benefit packages, continued in operation. Later, bowing to financial incentive, the offer of the shared-cost federal scheme could not be refused, and Ontario entered Medicare. Starting October 1, 1969, the Ontario Health Services Insurance Plan offered a universal medical plan that conformed to the conditions of the Medical Care Act.

In response to pressure from some of the larger private insurance companies, the government entered into an agreement with a consortium of 30 carriers whereby, on a cost-plus basis, they administered coverage, by a standard benefit package, for about one-third of Ontario residents.

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The arrangement proved cumbersome: both physicians and the public were confused about where to send claims; there were many lapses in coverage as people changed jobs; and, lack of uniform statistics made control of the program difficult.

On April 1, 1972, the Ontario Hospital Services Commission and the Ontario Health Services Insurance Plan were consolidated into the government-run insurance plan known as OHIP.

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1.2 The Current Health Insurance System

Being a universal comprehensive first dollar medical and hospital insurance scheme, OHIP has a public monopoly on provision to Ontario residents of insurance coverage for all medically-necessary hospital and physicians' care, and additional services provided by certain other health care providers. Legally, private insurers may only provide benefits for borderline services not included in the Plan, such as: hospital charges for private or semi-private accommodation; eye glasses; private duty nursing fees; transportation charges other than approved ambulance service; medical examinations or certificates required for applications for employment or the continuance of employment, life insurance, or admission to camps or recreational activities; cosmetic surgery; acupuncture; and, dental services other than a limited list of dental-surgical services provided by dentists in hospitals, and so on.

Because OHIP is partially financed by a premium system, it is possible for some residents of Ontario whose premiums are not paid up, to be "out-of-benefit" because of lapsed coverage. In order to satisfy the "universality" requirement, full or partial premium assistance is available based on taxable family income, and temporary assistance is available for those facing hardship as a result of unemployment or illness, etc., who would not otherwise be eligible for premium assistance. Persons, and their dependents, who qualify for provincial and municipal social assistance or who are 65 years of age or older and meet the residence requirements receive premium-free OHIP coverage. There is a generous reinstatement policy for those who are out-of-benefit and "good faith" payments are made on all first claims submitted by the physicians with respect to such persons.

OHIP pays benefits for insured services as follows:

- a) Physicians' Services (including unlimited psychiatric care)
- b) Hospital Services
- c) Extended Health Care (for those requiring medical supervision in nursing homes, etc.)
- d) Home Care (as an alternative to hospital care)
- e) Ambulance Services
- f) Dental Care in Hospital
- g) Optometric, Chiropractic, Osteopathic or Chiropodist Services

A complete description of these benefits can be found in the Appendix.

The actual administration of OHIP is complex. Public hospitals and extended-care services, paid for on the basis of a global budget, are administered by the Institutional Division of the Ministry of Health; Public Health Laboratories, ambulances and the provincial psychiatric hospitals are administered by the Direct Services Division. Venereal Disease clinics, home care, and the very limited number of non-fee-for-service physicians in Health Service Organizations, Community Clinics, etc., paid either on a capitation or a salaried basis, are administered by the Health Programs Division, while the Health Insurance Division administers payments to fee-for-service physicians, dentists, optometrists, chiropractors, osteopaths, chiropodists and physiotherapists, as well as private diagnostic facilities and out-of-province hospitals and medical practitioners.

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Payments are made either to the provider, or, in some cases, to the patient. Physicians and optometrists have the option of either submitting fee-for-service claims directly to OHIP and accepting as payment in full the amounts set out in the approved OHIP Schedule of Benefits, or of "opting-out", and billing their patients according to the Fee Schedule established by the profession, or an even greater amount, so long as there has been prior notification to the patient. Other practitioners, e.g., chiropractors, may or may not bill OHIP directly but whether or not they do, the patient is responsible for any difference between the amount allowed by OHIP and the amount charged by the practitioner.

Total expenditure by the Ontario Ministry of Health and the amounts spent to cover the complete OHIP program are shown in Table 1. Table 2 shows the expenditures on physicians' services since the start-up of OHIP in fiscal year 1972-3 up to fiscal year 1980-1.

TABLE 1ONTARIO

Ministry of Health Expenditures for Fiscal Year Ending March, 1981

by Major Spending Components

\$ million

OHIP Program

Public Hospitals	2,647.6
Extended Health Care	163.4
Psychiatric Hospitals	243.6
Ambulance Services	70.2
Public Health Laboratory Services	15.8
Home Care	47.0
Health Insurance Payments ⁽¹⁾	1,334.3

Sub Total	4,521.9
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Other Programs including

Ministry administration	336.2
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Total Ministry Expenditures ²	4,858.1
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(1) Includes fee-for-service and non-fee-for-service payments for physician and practitioner services in Ontario, and out-of-province hospital and medical expenditures.

(2) There are, of course, expenditures by other Ministries of the Ontario Government, e.g., Labour has responsibility for occupational health, etc.

Source: Ontario Public Accounts for 1980-81

TABLE 2: The OHIP Payment for Physicians and Practitioner Services
and for Out-of-Province Hospital and Medical Services FY 1973 - 1981
(\$ million)

Fiscal Year Ending March 31,											
		1973	1974	1975	1976	1977	1978	1979	1980	1981	
Fee-for-Service	Expenditure	539.5	552.4	640.3	728.3	784.0	881.9	1006.0	1071.2	1272.8	
	Cost per capita	\$66.43	\$66.72	\$74.75	\$90.03	\$95.93	\$106.34	\$122.23	\$132.37	\$156.23	
Percentage Distribution by Program	Medical	94.3	94.2	94.4	94.6	94.9	95.0	94.5	91.5 ⁽¹⁾	91.6 ⁽¹⁾	
	Dental	1.1	1.0	1.0	0.9	0.6	0.4	0.5	0.4	0.4	
	Optometric	1.3	1.2	1.4	1.5	1.6	1.7	1.7	1.6	1.6	
	Chiropractic	2.9	3.1	2.7	2.5	2.5	2.5	2.5	2.5	2.5	
	Osteopathic	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	
	Chiroprody	0.3	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	
Non Fee-for-Service Expenditures	Physiotherapy							0.5	0.8	0.7	
	Health Centres	2.1	3.1	3.5	4.6	4.7	3.7	4.2	5.8	10.4	
	Salaries	{ Included in 539.5 Expenditure above.	4.2	5.2	8.5	10.7	11.6	12.2	11.6	11.6	
	V.D. Clinics		0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5	
T.B. Clinics	0.4		0.2	0.5	0.5	0.6	0.5	0.3	0.4		
TOTAL		541.6	560.5	649.6	742.1	800.3	898.2	1023.3	1089.3 ⁽¹⁾	1295.70 ⁽¹⁾	
Includes Out-Of-Province physician and hospital 1973-1979 in Fee-For-Service expenditures and in the proportion of payment for the "Medical" program. (1) Excludes Out-Of-Province Source: Ministry of Health Annual Reports											

Includes Out-of-Province physician and hospital 1973-1979 in Fee-for-Service expenditures and in the proportion of payment for the "Medical" program. (1) Excludes Out-of-Province

Source: Ministry of Health Annual Reports

7.2 Physicians in Ontario

7.2.1 Alternative Methods of Physician Compensation

It is clear from Table 2 that the vast bulk of physicians' income in Ontario is received in the form of payments for fee-for-service claims paid by OHIP. Other modes of remuneration, i.e., salary and capitation payments, amount to only about 2 per cent of the fee-for-service payments from government. These non-fee-for-service programs are regarded essentially as experimental in nature. There are a number of Health Service Organizations, similar to HMO's in the United States. Some are relics of pre-medicare days, having been started, for example, by trade unions as alternatives to then existing private insurance. Clinics with salaried physicians have been established to cater to community needs or to special needs of transients, or deviant groups, such as, youth in the drug sub-culture.

But physicians also have some income for professional services from private sources, such as: insurance examinations; legal reports; treatment of non residents or members of the Armed Forces; cosmetic surgery; and, school board or private company employment, etc. In some specialized areas of medicine, such as psychiatry or plastic surgery, a substantial portion of income may be from such sources.

The single largest source of private funding for physicians' services comes from the opportunity, under the Ontario Health Insurance Act, to "opt-out" of OHIP and to bill patients directly for services rather than billing the Plan. In general, if the physician opts-in, and bills the Plan, he is obliged to accept the Plan benefit as full payment. Historically, between 10 - 18 per cent of physicians have chosen

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to work outside the Plan and have consequently been free to "extra-bill", i.e., charge more than the Schedule of Benefits fee.

Legislation was introduced the year before OHIP was set up in April, 1972 to provide for what has been called "practice-streaming" which made it mandatory for a physician to choose one of two methods of billing (either direct billing of the patient for the full fee or remuneration by the government plan at the established schedule of benefits) for his entire practice. However, it was not until April, 1972, that this legislation became enforceable with the elimination of private carriers and consolidation of all billing records in the OHIP computer. Subsequently, certain exceptions to the "practice-streaming" requirement have been permitted. In 1972, opted-out physicians were allowed to bill OHIP for services provided to war veterans, treaty Indians, on a 'good samaritan' basis, or, to patients seen in certain group practices registered with OHIP and affiliated with a public hospital. In 1973, the 'good samaritan' provision was reversed and in 1974, hospital groups were restricted to those affiliated with teaching hospitals or the emergency department of a public hospital. In 1976, opted-out physicians were permitted to bill the Plan for services in nursing homes, homes for the aged, sanatoria and psychiatric hospitals; and, in 1978, permission was again granted to members of groups associated with any clinical department of a public (not just a teaching) hospital.

The physician billing on an opted-out basis submits accounts to OHIP on his patient's behalf. OHIP then makes a payment to the subscriber at

the amount authorized in the OHIP Schedule of Benefits. The physician may "extra-bill" the patient in an amount greater than the Schedule of Benefits fee. This extra amount may be up to, or, with prior notification to the patient, even beyond the amount set out in the Ontario Medical Association Fee Schedule. At present, (1981), fees in the OHIP Schedule of Benefits are on average about 30 per cent lower than those provided in the OMA fee schedule.

About 10 per cent of OHIP billings, estimated in fiscal year 1981-82 to be about \$1.3 billion, are billed on an opt-out basis. If physicians were successful in recovering the full OMA rate on the entire opted-out billing of about \$130 million, they would receive about \$57 million in private funds. The amount that is extra-billed, of course, varies by specialty. In general, those specialists that have no opportunity to vary the mix of services provided, such as, obstetricians, anaesthetists and psychiatrists, (the latter two groups having only time to sell), exhibit both the highest percentage of opting-out, and extra-bill by the largest amounts. Referring to private income, the current (1982) Chairman of the Joint Committee on Physicians' Compensation for Professional Services, in his fact finder's report of March 8, 1982, stated that "a conservative estimate (extrapolated from Ontario Medical Association surveys of several years ago) would add a minimum of \$3,000 to the general practitioners' figure /for average income/ and \$6,000 to that of the specialist (although the actual distribution of this private money is undoubtedly more skewed than the distribution of the public funds)."⁶ Applying his estimates to the number of physicians who bill OHIP, the result is an estimate of about \$58 million in private funds or about the same as the estimate assuming that opt-out physicians recover the full difference between the Schedule of

Benefits and the OMA Fee Schedule.

Levels of payments under alternative methods of physician compensation in Ontario are shown in Table 3.

TABLE 3

Estimated Gross Physician Compensation in Ontario
Under Alternate Methods of Physician Compensation

FY 1981-82

(\$ million)

Method	Determination of Level of Compensation	
	Market	Negotiation ¹
Fee-For-Service	60.0	1.300.0
Capitation	Nil	10.4
Salary	No Data	11.6

(1) Includes about \$20 million in Workmen's Compensation payments.

7.2.2 Distribution of Physicians by Type of Practice (Solo, Group)

There are no established criteria in Ontario for defining practice types. OHIP registers "physicians", i.e., persons licensed to practice medicine by the College of Physicians and Surgeons of Ontario, and keeps on file information required to assess claims, e.g., Certification by the Royal College of Physicians and Surgeons of Canada which entitles a physician to be paid at specialist rates. It does not, however, register practices as such, although physicians may, for their own convenience, request registration as a group for billing purposes. Consequently, there are no official statistics on practice type.

Moreover, the criteria for defining "group practice" have not been universally agreed upon in Ontario by researchers of this phenomenon. Most surveys, however, have considered some income-sharing arrangement to be a crucial characteristic of this form of practice.

Data from a survey conducted in 1976 by Wolfson, Tuohy and Shah, suggest that about one-fifth of Ontario fee-for-service physicians practise in groups, that is, in association with other physicians with whom they have an agreement to, among other things, pool and re-
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distribute practice revenues. It must be noted, of course, that this figure slightly underrepresents the true proportion of group practitioners among Ontario practising physicians, since several groups have negotiated non-fee-for-service modes of remuneration with



the Ministry of Health. Since the survey confined itself essentially to fee-for-service physicians, moreover, the data were not strictly comparable with earlier studies suggesting a trend toward group practice in Ontario. A report to the Hall Commission, in 1962, noted that 10.7 per cent of practising physicians in Ontario were in groups of at least three physicians involving more than one specialty who pooled and redistributed practice revenues. In 1967, a Canadian Medical Association Manpower Survey, using an essentially similar definition of group practice but allowing for single specialty as well as multi-specialty groups, found that 25.3 per cent of practising physicians in Ontario were group practitioners. The Wolfson et al survey estimated that 13.5 per cent of Ontario physicians practise in groups as defined by the 1962 report, and 19.5 per cent in groups as defined by the CMA and noted that another 14 per cent share expenses with colleagues.

A sizeable minority of Ontario fee-for-service physicians are affiliated with the major medical institutions: the hospitals and medical schools. About one-quarter are affiliated with medical schools; and just under one-half have served on the Medical Advisory Committee of a hospital, i.e., the Senior hospital committee. The average fee-for-service practitioner is a member of two hospital staffs, although this overall figure may mask disparities within the profession which has made the granting of hospital privileges a political issue in the past.

7.2.3 Distribution of Physicians by Specialty

Just as the essentially private nature of fee-for-service medical practice in Ontario frustrates the attempt to describe the types of practice that exist, so it also makes difficult the seemingly simple task of counting the number of doctors.

Information supplied to the Ontario Legislature Select Committee on health costs in July, 1978 indicates that the College of Physicians and Surgeons of Ontario had on file about 16,300 physicians licensed to practice medicine in Ontario, of whom about 1,300 were "out-of-province, etc."¹⁰ At that time, according to the Ministry submission, there were about 11,500 "practising physicians in Ontario". "Practising" was defined as generating any fee-for-service billings to OHIP, both opt-in and opt-out, over the three month period July to September, 1977. Of the remaining 3,500 physicians, some, certainly, would submit claims to OHIP at other times during the year; and others were in fact engaged in the full-time practice of medicine on a salaried or capitation basis.

Of course, among this group of 3,500 are included some retired physicians, but it is also true that among the 11,500, there are as well many physicians who are not engaged in full-time practice, including many who are virtually retired.

Since the inclusion of part-timers, when calculating average physician incomes for purposes of fee negotiation between the government and the profession produces a bias, there has been a long-standing

THEORY OF THE EARTH

The theory of the earth is a branch of geology which deals with the origin and development of the earth and its various parts. It is a science which seeks to explain the processes which have shaped the earth and its features, and to determine the time and sequence of these processes.

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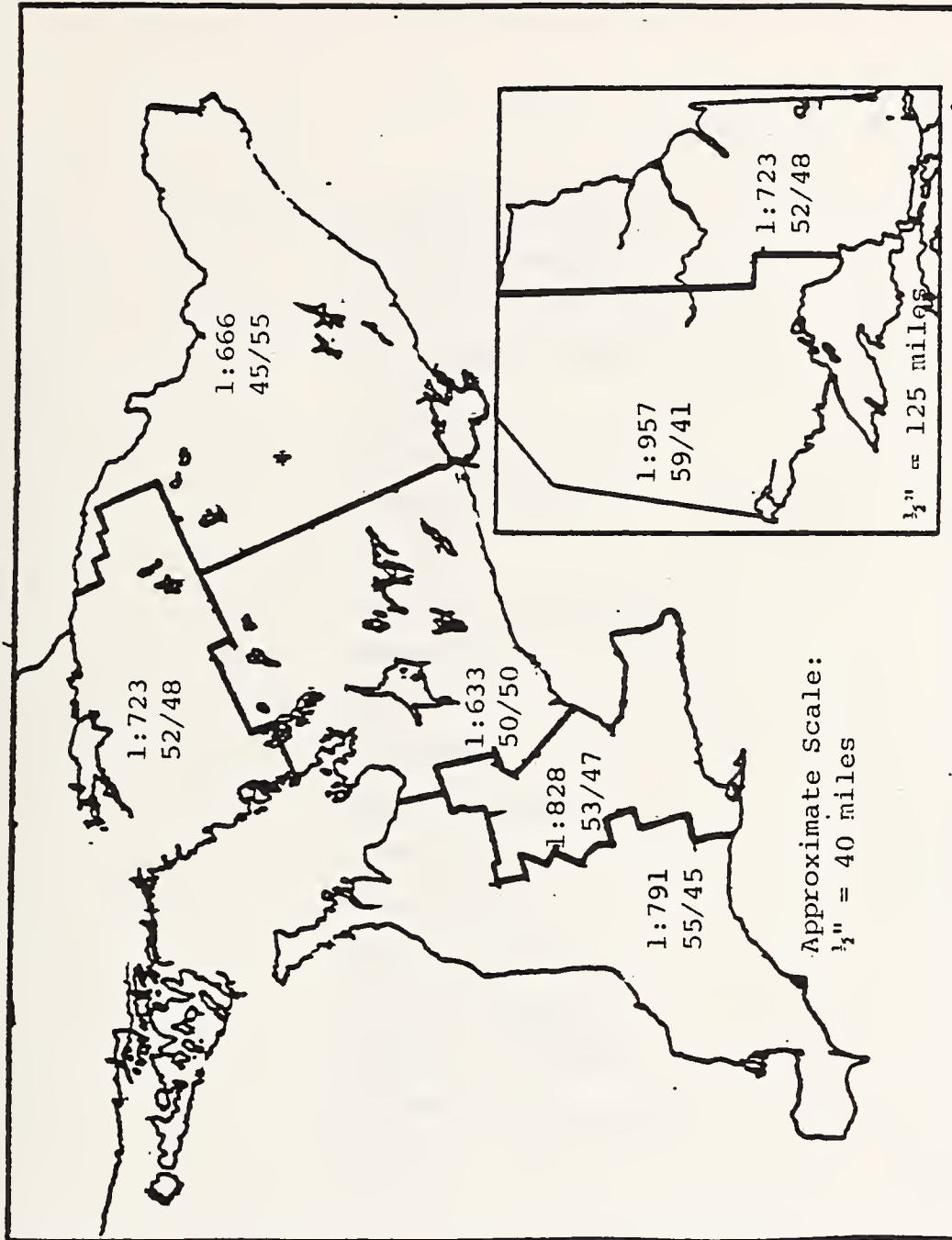


Figure 1 Physician Distribution in Ontario
Ratio of all physicians billing OHIP to population and
General Practice/Specialist Ratio July - Sept. 1977.

Source: "Supplementary information to the Ministry of Health
Presentation on Health Care Costs" Select Committee on
Health-Care Financing and Costs Tabled July 20, 1978 Part B pp. 13-19.



TABLE 4

Distribution by Specialty, Ontario Physicians
Billing OHIP in January, 1981

General Practice	6254
General Surgery	657
Internal Medicine	1049
Obstetrics & Gynaecology	521
Pediatrics	452
Orthopedic Surgery	255
Otolaryngology	193
Urology	153
Diagnostic Radiology	416
Anaesthesia	514
Neurology	102
Psychiatry	868
Ophthalmology	291
Dermatology	134
Neurosurgery	50
Plastic Surgery	90
Thoracic Surgery	33
Physical Medicine	50
Therapeutic Radiology	40
Others	<u>116</u>
 All Physicians	 12,238

dispute between the parties to the negotiation about the criteria that should be used to classify physicians as "part-time". In the current negotiations, the profession has argued that the cut-off point should be the 25th percentile, while the government has maintained that the 30th percentile is more appropriate.¹¹ By either criterion, a substantial proportion, about 25 per cent, of the 11,500 so-called "practising" physicians are not engaged in the full-time practice of fee-for-service medicine.

Slightly more than half of practising physicians in Ontario are general practitioners, with the proportion of specialists being higher in the more densely populated southern part of the province, and being particularly high in Metropolitan Toronto. Figure 1 shows the ratio of general practitioners to specialists in the various regions as well as the ratio of all fee-for-service physicians to population as of mid 1977. Table 4 shows the distribution by specialty.

There was an annual growth in the physician stock of about 4 per cent in the first few years of OHIP operation. This fell to about 1.5 per cent when immigration controls were introduced in 1975, remained in that range through the last half of the seventies, and has risen to 2.5 per cent per year in the early eighties.¹²

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1801. It is a very important document, as it is the first official communication of the new administration. The President, James Madison, discusses the state of the Union and the challenges facing the new government.

2. The second part of the document is a report from the Secretary of the Treasury, James Callaghan, dated January 1, 1801. It provides a detailed account of the financial state of the United States at the time. The report discusses the national debt, the state of the treasury, and the measures being taken to manage the country's finances.

3. The third part of the document is a report from the Secretary of the Navy, John Adams, dated January 1, 1801. It provides a detailed account of the state of the Navy at the time. The report discusses the fleet, the personnel, and the measures being taken to strengthen the Navy.

4. The fourth part of the document is a report from the Secretary of the War, James McHenry, dated January 1, 1801. It provides a detailed account of the state of the War Department at the time. The report discusses the military forces, the equipment, and the measures being taken to prepare for war.

5. The fifth part of the document is a report from the Secretary of the Interior, Thomas Mifflin, dated January 1, 1801. It provides a detailed account of the state of the Department of the Interior at the time. The report discusses the land, the resources, and the measures being taken to manage the interior.

6. The sixth part of the document is a report from the Secretary of the State, James Madison, dated January 1, 1801. It provides a detailed account of the state of the Department of State at the time. The report discusses the foreign relations, the treaties, and the measures being taken to manage the state.

2.4 Practice Revenues and Expenses

In Ontario, a physician's net income from practice is determined not only by his specialty which determines the type of work he does, the fees he can charge for doing it, and, the expenses that he must incur to conduct his practice, it is also heavily influenced by whether he has chosen to opt-in or out of OHIP. An opted-out physician can vary his prices, and faces, at the very least, the additional business expense of billing his patients, and, of course, is in competition for patients with other physicians who do not extra-bill. Because of the different underlying factors at work, it is important to consider separately opted-in and opted-out physicians and to separate them into the various specialty groups. Comparisons of practice revenues and expenses will thus be made within categories of specialty and option. Survey data that allow these comparisons to be made were gathered in 1976 by Wolfson, Tuohy and Shah and are summarized in Table 5. The survey data cover only gross income received as a result of fee-for-service billings either to OHIP or to patients, and thus include extra-billings, but do not include Workmen's Compensation payments, insurance company examinations, and services such as acupuncture that are not benefits of OHIP.

The survey estimated net income of all full-time physicians, both opted-in and opted-out, at \$46,066 which, considering the exclusions, is comparable to the \$47,200 income reported by Ontario physicians by the Canada Department of National Health and Welfare based on income tax data for that year. Practice expenses, as a proportion of gross practice income, was reported by respondents to the survey as 34.7 per cent

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TABLE 5

Income and Expenses of Practice by Option Type and Specialty Group

	ALL IN & OUT	OPTION	GENERAL PRACTICE	MEDICAL SPECIALTIES	OBSTETRICS/ GYNAECOLOGY	SURGICAL SPECIALTIES	ANAESTHESIA	PSYCHIATRY	ALL
gross income from medical practice =342)	67,937.11	IN	61859.02	91760.06	71319.25	79244.50	70392.94	44798.53	67665.00
practice expenses: total =342)	22,064.22	OUT	47238.66	58590.36	84616.31	98635.37	59765.50	62547.52	70011.25
		IN	22724.00	26273.49	23316.66	21353.14	7581.91	10807.48	21809.95
		OUT	23755.99	22074.17	32653.91	27914.76	7198.68	20361.88	24001.90
practice expenses: bour	7,017.60	IN	9410.96	11264.26	10914.48	8722.98	2203.59	3996.53	9012.37
		OUT	10450.97	8770.16	14214.12	11299.56	2319.67	4401.66	9507.14
practice expenses: erhead	12,952.66	IN	13293.66	15009.23	12402.18	12631.75	5231.41	6810.94	12785.90
		OUT	13513.46	13304.00	17920.32	16500.68	4879.01	15960.21	14460.20
practice expenses as a percentage of gross practice income =342)	34.7	IN	38.23	39.29	35.48	29.61	11.77	25.02	34.30
		OUT	54.99	37.60	37.54	30.55	12.11	33.50	37.86
net income from medical practice =342)	46,066.41	IN	39135.02	67651.75	48002.68	57891.42	62811.06	33991.05	46088.73
		OUT	23266.89	36516.20	51962.42	70720.69	52566.82	41837.23	45896.25

Source: Wolfson et al What do Doctors Do?

of gross revenues. This proportion is almost identical to the Canada-wide average reported in a survey conducted by the Canadian Medical Association in 1967, which showed practice expenses of 33.4 per cent for solo practitioners, 33.7 per cent for those in partnership and 34.7 per cent for group practitioners. The latest National Health and Welfare tax-based statistics indicate that expenses have been rising as a proportion of gross income to 36.9 per cent in 1979, but the fact finder in the present negotiations was loathe to project this trend into 1982 because it was felt a complex set of circumstances determines fluctuations in expenses as a proportion of gross income over time. Income after expenses, of course, has also risen since then, and the fact finder's report estimates with respect to 1981 that the average net income for full-time general practitioners was \$70,000 per year while the average net figure for full-time specialists was \$101,000 per year.

Returning now to the survey results, Table 5 shows the impact of specialty and option on physicians' gross income, expenses, and net income.

Income, both gross and net, and the financial effects of opting-out, varied considerably across specialties. The net practice incomes of opted-out general practitioners, medical specialists and anaesthetists were lower than those of their opted-in counterparts; in the cases of obstetrics and gynaecology, surgical specialties, and psychiatry, opted-out net incomes were higher.

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1801.

2. The second part is a report from the Secretary of the Treasury, dated January 1, 1801.

3. The third part is a report from the Secretary of the Navy, dated January 1, 1801.

4. The fourth part is a report from the Secretary of the War, dated January 1, 1801.

5. The fifth part is a report from the Secretary of the Interior, dated January 1, 1801.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1801.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1801.

8. The eighth part is a report from the Secretary of the Navy, dated January 1, 1801.

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11. The eleventh part is a report from the Secretary of the War, dated January 1, 1801.

12. The twelfth part is a report from the Secretary of the Navy, dated January 1, 1801.

13. The thirteenth part is a report from the Secretary of the Treasury, dated January 1, 1801.

14. The fourteenth part is a report from the Secretary of the State, dated January 1, 1801.

Considering the cases of general practice and medical specialties, the survey revealed that the clinical workloads of opted-out physicians in these two groups, as reflected by their patient loads and their OHIP billings, were significantly smaller than the workloads of their opted-in counterparts. It is apparent that these smaller workloads resulted in lower gross practice incomes, even after price had been taken into account. Furthermore, the proportion of gross practice income which went to practice expenses was significantly higher for these two groups of opted-out physicians than it was for their opted-in peers. The effect of these proportionately greater practice expenses was to make the relative position of opted-out general practitioners and medical specialists even less favourable in net than in gross terms.

Opted-out general practitioners and medical specialists had lower gross incomes from medical practice, proportionately higher practice expenses, and lower net incomes from medical practice than did their opted-in counterparts. In the case of these two groups, the charging of prices above the OHIP benefit appeared to be a financially costly decision. General practitioners were most likely to suffer a reduction in patient demand by opting-out, since they offer care on a continuing, rather than an episodic basis, and to families rather than to individuals. Facing such risks, moreover, most general practitioners did not opt-out, and those who did were, therefore, subject to considerable competitive pressure. Medical specialists, particularly internists, to the extent that they function as primary care or family physicians, may face similar problems.

1. The first part of the document is a letter from the President of the United States to the Congress.

2. The second part is a report from the Secretary of the Treasury on the state of the Union.

3. The third part is a report from the Secretary of the Navy on the state of the Navy.

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28. The twenty-eighth part is a report from the Secretary of the Education on the state of the Education.

29. The twenty-ninth part is a report from the Secretary of the Health on the state of the Health.

30. The thirtieth part is a report from the Secretary of the Labor on the state of the Labor.

31. The thirty-first part is a report from the Secretary of the Justice on the state of the Justice.

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33. The thirty-third part is a report from the Secretary of the War on the state of the War.

34. The thirty-fourth part is a report from the Secretary of the Navy on the state of the Navy.

35. The thirty-fifth part is a report from the Secretary of the Interior on the state of the Interior.

In the case of the surgical specialties and psychiatry, gross professional incomes of opted-out physicians were higher than those of opted-in physicians.

Before leaving the subject of physicians' incomes, it is interesting to compare over time the incomes that physicians earn from fee-for-service practice to the incomes of other fee-for-service professional groups in Ontario and to the level of incomes in general. Table 6 shows the Ontario industrial composite wage for the period 1961 to 1979 and expresses the incomes of physicians, dentists, accountants, lawyers, and, engineers/architects as a multiple of that wage. The picture over the 19 year period is a surprisingly fluid one. Certainly, in all but one year, physicians were the leading net income earners, with income between a low of 4.0, and a high of 5.7, expressed as a multiple of the average industrial wage. But the relative fortunes of the various professions reflect the impact of a variety of economic forces. The extension of medical insurance in 1966 and the introduction of Medicare in 1969 parallels the relative rise of physicians' incomes from about 4 times, to levels well above 5 times the industrial wage, but the upward trend was apparent even before this time. Much to the dissatisfaction of the medical profession, physicians' relative incomes have fallen back to around the 4 times level. Over the 19 year period, dentists have gradually improved their incomes to levels approaching that of physicians, perhaps in response to the broadening of benefits for dental services being negotiated as part of the compensation package under numerous collective agreements. But accountants have not improved their relative incomes, and lawyers, and engineers/architects have both fared poorly in the late 1970's compared to 1961.

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TABLE 6

AVERAGE NET INCOME AS A MULTIPLE OF AVERAGE INDUSTRIAL WAGE
FOR ONTARIO PROFESSIONALS BASED ON TAXABLE RETURNS, 1961-1979

Year	Physicians	Dentists	Accountants	Lawyers	Engineers & Architects	Ontario Industrial Composite
1961	4.3	3.1	2.9	4.3	3.2	\$ 4,228
1962	4.5	3.5	2.7	3.9	3.1	4,350
1963	4.7	3.3	2.5	4.1	3.3	4,483
1964	5.0	3.5	3.0	4.3	3.5	4,671
1965	5.2	3.6	2.9	4.5	3.9	4,909
1966	5.3	3.6	3.0	4.8	4.2	5,169
1967	5.6	3.6	2.8	4.7	3.9	5,505
1968	5.6	3.7	3.1	4.7	3.8	5,904
1969	5.7	3.9	3.0	4.9	3.7	6,321
1970	5.7	3.7	3.3	4.8	3.2	6,841
1971	5.7	3.8	2.8	4.3	3.0	7,438
1972	5.3	3.9	2.8	4.3	2.7	8,056
1973	5.0	3.8	3.6	4.9	3.2	8,612
1974	4.7	4.0	3.6	5.1	3.9	9,434
1975	4.3	4.2	3.6	4.3	4.2	10,652
1976	4.1	3.9	3.7	4.1	2.8	11,893
1977	4.0	3.7	3.3	3.6	2.7	12,972
1978	4.1	3.7	3.3	3.4	2.2	13,730
1979	4.1	3.8	3.1	3.4	2.4	14,850

Source: Report of the Chairman of the Joint Committee on Physicians' Compensation for Professional Services. 1982 P.30

3 Fee Schedules Used Under Fee-For-Service Compensation

3.1 Determination of the Fee Schedule

There are a number of different dimensions to the historical development of fee schedules. These have all played their part in Ontario. More recently, there was a need to standardize communications between physicians and the many private agencies that were entering the field of medical care insurance. By the advent of Medicare, in 1969, the Ontario Medical Association (OMA) fee schedule was in use by most medical practitioners as a guide in setting their fees, and by medical insurance plans as the basis for benefits to their subscribers. This widespread acceptance attests to the care which had been expended by the profession to construct a realistic schedule and to keep it up to date through regular revisions.

As the private preserve of the profession (before Medicare was introduced), the fee schedule was approved by the Council of the OMA on the advice of the Board of Directors, the Committee on Economics, and the Committee on Tariff. Prime responsibility for the schedule rested with the Committee on Tariff who carried out continuous study and made recommendations based on submissions by the sections of the OMA representing the various specialties. It was the central Committee on Tariff that was the arbiter of the relative values of medical acts, and of the impact, so far as it could be estimated from a fee schedule, of fees on the relative incomes of the different specialty groups.

THE HISTORY OF THE UNITED STATES

CHAPTER I

THE DISCOVERY OF AMERICA

It is generally supposed that Christopher Columbus discovered America in 1492. But it is not true. He was not the first European to reach the continent. He was only the first to reach it by sea.

The first European to reach America was Leif Erikson, a Norseman, in 985.

He was followed by John Cabot, an Italian, in 1498.

He was followed by Amerigo Vesputi, an Italian, in 1499.

He was followed by Vasco Nunez de Balboa, a Spaniard, in 1500.

He was followed by Hernan Cortez, a Spaniard, in 1519.

He was followed by Francisco Pizarro, a Spaniard, in 1532.

He was followed by Juan Ponce de Leon, a Spaniard, in 1513.

He was followed by Pedro de Mendez, a Spaniard, in 1519.

He was followed by Vasco da Gama, a Portuguese, in 1498.

He was followed by Bartolomeu Dias, a Portuguese, in 1488.

He was followed by Henry the Navigator, a Portuguese, in 1419.

He was followed by Prince Henry, a Portuguese, in 1419.

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Though there were extensive consultations between third party payers and the OMA, the fee schedule was promulgated unilaterally by the professional association. When Medicare came into effect, in 1969, the fee schedule, insofar as it constituted the basis for a schedule of benefits, became subject to negotiation with the government, but the first negotiations did not occur until 1974. In the meantime, the 1971 fee schedule was developed unilaterally, as it had always been done, by the OMA. By decree of the Minister of Health, the OMA Fee Schedule was adopted, pro-rated at 90 per cent, as the OHIP Schedule of Benefits. The 10 per cent discount was an allowance for the fact that physicians were now guaranteed payment for their services from a single government agency, with no bad debts anticipated and the billing process streamlined.

In terms of the general economics of the health care sector, the early 1970's, with the whole Medicare program finally in place, was a period of very great uncertainty with the most basic question being whether it would be possible to control the costs of the program. Health care costs had been going up rapidly in the 1960's, largely in response to increasing wage demands of hospital workers toward the end of the decade. Indeed, one of the reasons for bringing in medical insurance was to correct what was perceived to be an "insurance bias" toward inappropriate, and hence unnecessarily costly, institutional care.

In this atmosphere of uncertainty, fundamental policy questions were being asked. Would salary or capitation arrangements for physician compensation promote more efficient and more effective delivery of

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ambulatory care than would continuation of the overwhelming reliance on the fee-for-service arrangement? What role, if any, should nurse practitioners and other physician "extenders" play? How should the government best address the issue of securing the optimal distribution of physicians by specialty and by geography?

The Ontario version of Medicare, in which a well-established profession, largely self-employed in fee-for-service practice, faced an essentially monopsonistic public plan, was breaking new ground, and there were neither precedents to guide it, nor, more importantly, institutional mechanisms for maintaining it. In particular, there was the immediate problem of revising the fee schedule, which had hitherto been revised every two years, and was, therefore, due for revision in 1973.

In this climate, the OMA seized the initiative and commissioned the "Pickering Report", a fundamental review of the prospects for fee-for-service ambulatory care in Ontario, including a review of the question of the appropriate institutional arrangements for revising the structure and level of benefits to be paid by OHIP.¹³ In early 1973, Pickering recommended that a committee be established as a cooperative effort between the OMA and the government. In the meantime, the Schedule of Benefits, based on 90 per cent of the 1971 Fee Schedule, remained in effect. It should be noted that physicians in Ontario were, at this time, at the apex of their relative earning power, with income 5.7 times that of industrial workers, compared to an historical ratio of about four to one, and that it was a period of relatively low rates of inflation. It was the political, not the economic climate, that

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Was uncertain, and there was a pause in fee schedule increases as the question of appropriate institutional arrangements was addressed.

In October, 1973, after six months of discussions between representatives of the government and the OMA, the Premier announced the establishment of a standing "Government of Ontario - Ontario Medical Association Joint Committee on Physicians' Compensation for Professional Services". In a document prepared by the two parties, the announced purpose of the Committee was to recommend:

".....to both the OMA and the Government of Ontario a fair basis of compensation for all practising physicians, with due consideration to both patient needs and the costs to the Province of Ontario. The OMA, through its Tariff Committee, will continue to be responsible for the details of the Schedule of Fees. The Government of Ontario will continue to decide the mechanisms to be used to pay for health services used by residents of the Province. However, in a fee-for-service system of payment, a schedule is only a means of achieving an end. Consequently, the Joint Committee will not be precluded from reviewing the Schedule and making recommendations with respect to individual items which are regarded as contributing to inequities or which require revision to achieve an objective. The Committee will also attest to the adequacy of the Schedule as a whole."

The joint announcement went on to note that the Joint Committee approach was "designed to minimize the 'adversary' concept", and that it represented an attempt "to avoid fixed, rigid positions being taken which could interfere with the necessary cooperation and collaboration required of both Government and the profession to further the best interests of the public".

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The Joint Committee, reporting to the Premier of Ontario and to the President of the OMA, was to consist of three representatives of each side with a neutral chairman who was expected to take actively a creative leading role. It would not be an overstatement to say that the concept of the chairmanship was that of a deus ex machina capable of reconciling, without conflict, stewardship of the public purse, on the one hand, with, on the other hand, the economic interests of the most highly paid occupational group in the province.

In order to accomplish this providential interposition, the chairman was given wide latitude to commission research and the Joint Committee was given very broad terms of reference. Not only was it to deal with all matters that might conceivably bear on the subject of a global revision of the fee schedule, but it was specifically mandated to consider two other areas that go considerably beyond that. The first of these additional areas was: "trends in utilization of services". In other words, the whole subject of the rate of contacts of patients with physicians and the volume and mix of services during these contacts was to be a subject of review by the Joint Committee. The second additional area covered a broad range of policy questions including:

- the suitability of alternative methods of compensation for different specialties or different modes of practice,
- cost of services delegated to paramedical personnel, and reimbursement mechanisms for these services,

- the effect of technological advances in medical practice including physicians' output,
- regional requirements for medical services.

The question of why these terms of reference were viewed by the Joint Committee as something of a Pandora's box will be dealt with in the last part of this chapter when we review the development of fee negotiation and look at emerging problems and policy options. It is sufficient for now to note that, in 1973-74, the Joint Committee restricted itself to: (1) negotiating a "global revision" i.e., a percentage increase in prices using past utilization as the weights when summing across different services; (2) agreeing to maintaining the Schedule of Benefits at 90 per cent of the OMA Fee Schedule; and, (3) negotiating a two-year agreement calling for an upward global revision of fees of 7.75 per cent in May 1974 and an additional 4.0¹⁵ per cent in May 1975.

The rise in the rate of inflation during the next two years was higher than had been anticipated and in February 1975, the OMA sought to reopen negotiations with respect to the May increase. The government refused and the OMA responded by putting it on notice that henceforth the bargaining process would apply only to the OHIP "schedule of benefits" and not to the OMA fee schedule itself. The latter would be set by the OMA unilaterally as a guide to opted-out physicians who bill their patients directly and do not submit accounts to OHIP. In October, 1975, the federal government introduced a program of wage and price controls that severely curtailed the scope of what physicians could demand, and in 1976, federal anti-combines legislation was introduced which cast doubt on the legality of an OMA fee schedule except as a

schedule of benefits for payments to physicians under OHIP. There can be little doubt that these federal initiatives, which were in no way aimed specifically at Ontario physicians, had the effect of preserving the facade of the accommodation that had genuinely, if naively, existed between the government and the OMA, in October of 1973, when the Joint Committee was first announced. But behind the facade, events were moving toward open confrontation.

In 1976, a cross-provincial study of government controls on the health care system noted that, while in previous negotiations "an overall rate of increase in fees was negotiated and then the Medical Association established individual fees within this overall limit, in the current (1976) negotiations, the process of establishing a Medical Association fee schedule is occurring concurrently and independently of the negotiations".¹⁶ The report went on to note that while the negotiation process in the past had been described as "one of low conflict and high cooperation, the current negotiations are somewhat more adversarial in character".

In 1978, physicians began to move out from under federal price controls as their individual taxation years ended. Bargaining between the OMA and the government intensified. First, the Joint Committee formally narrowed the scope of its terms of reference. It stated, in its report of that year that, "while the Committee reserves the right to review the allocation of the increase among the various specialties, the OMA has the initial responsibility for proposing such

allocation". Second, the OMA unilaterally increased its 1978 fee schedule, effective May, 1978, by 36 per cent, thus ending the 90 per cent pro-ration, but not the proportionality, between it and the OHIP Schedule of Benefits. Furthermore, it maintained in its negotiations with the government that if a large increase in the OHIP schedule was not forthcoming, that a large number of physicians would opt out and charge the OMA rate. Despite this argument, the government held to a 6.25 per cent increase in the 1978 schedule of benefits. Subsequently, the profession has accepted upward global revisions in the schedule of benefits of 6.6 per cent effective January, 1979, 11.5 per cent effective January, 1980 and 14.75 per cent in April, 1981. Throughout this time, the OHIP schedule of benefits has been about 70 per cent of the OMA fee schedule and the Association has exhorted its members to opt out of OHIP and to deal directly with patients.

In the more recent negotiations, the Joint Committee has been established on the basis of a "Memorandum of Agreement" subject to periodic revision on the basis of mutual agreement between the parties. The Agreement, covering negotiations for the 1981 schedule, explicitly restricted the function of the committee to "negotiations
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between parties with respect to global revision". The Agreement, covering the 1982 negotiations was amended, slightly, by adding to global revision, "all other matters of a fiscal nature which are mu-
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tually agreeable to the parties".

"Global revision" is defined in the Agreement as "a percentage change in the total amounts payable in the Schedule". Left unsaid, in this definition, is that the weights used in summing the product of price and utilization for each medical act in the fee schedule in order to arrive at the "total amounts payable", are utilization figures from the previous year. "Changes in individual amounts and in nomenclature, definitions and preambles in the Schedule" are, in the Agreement, referred to as "detailed allocation". The Agreement states that: "Where the Committee has recommended an agreement with respect to the global revision and the parties have entered into the agreement, the OMA will determine the detailed allocation subject to the approval of the Lieutenant Governor in Council", (i.e. the provincial Cabinet).²⁰

To sum up, the first Schedule of Benefits under Medicare was simply a 90 per cent pro-ration of the OMA Fee Schedule which had been set unilaterally by the OMA.

Subsequently, a Joint Committee of the OMA and the Government was set up with broad terms of reference to review all aspects of physician compensation, including the fee schedule. The Committee restricted itself to recommending a global revision that would be acceptable to both parties. After the global revision was agreed, the OMA simulated, using the OHIP computer, various detailed allocations across fee schedule items based on recent data on utilization to arrive at a relative price structure for fees that, pro-rated at 90 per cent, would fit the agreed global award. No attempt was made by the government

to take advantage of the opportunity to use the fee schedule to influence physician practice behaviour.

The government did, however, support OMA efforts to adjust the relative fee levels to achieve a redistribution of income among specialty groups. In particular, the OMA had, since at least as early as 1967, been adjusting fees in an attempt to narrow the gap between General Practitioners and specialists. The rationale for these attempts has never been fully articulated. For example, in the 1960's, arguments were made that adjustments were needed to prevent distortion of the supply of physicians since it was felt that there was a surplus of physicians in certain specialties and a shortage of "family" physicians. More recently, such other long term goals have been advanced as assuring that average net lifetime earnings are equal across specialties, or that variations at least reflect "relative stress of practice".^{21a}

Aside from this endorsement of specialty redistribution, the government established the precedent in the first negotiation of leaving the detailed allocation of relative prices to the OMA.

This is not to say that there is no collaboration between the OMA and the government on the clinical content of the fee schedule. Indeed, there is a continuous informal exchange of views between the Committee on Tariff and physicians employed by OHIP. But this is merely continuation of the long established customary practice of consulting the insurance agencies. The government may, if it so chooses, reject or modify any fee in the OMA schedule in establishing the OHIP Schedule of Benefits, but has not pursued an independent course in this regard.

By the mid 1970's, the pattern for fee setting was so well established that the OMA was setting its fee concurrently and independently of the negotiations, which were concerned only with the global revision. In 1978, the practice of adopting the OMA schedule, prorated at 90 per cent, as the OHIP Schedule of Benefits was discontinued, putting the OMA back into the same position that had existed prior to Medicare; namely, unilaterally setting both the relative and absolute levels of fees. However, since 90 per cent or so of services are billed to OHIP, rather than to the patient, the effective absolute level of fees is that set out in the OHIP Schedule of Benefits, the global revision of which has been negotiated by the Joint Committee.

Negotiations have become more and more acrimonious. In 1981, agreement between the parties was reached only after the Chairman of the Joint Committee made recommendations in the capacity of a fact-finder. In 1982, negotiations broke down and the fact-finder's report did not produce an acceptable recommendation. On expiration of the agreement on April 1, 1982, the Minister of Health imposed an upward global revision of fees of 11 per cent over nine months with suggested staged increases over the next three years. Whether or not the Joint Committee approach will survive the current breakdown, is a question that cannot be answered at this time. As a final observation on the determination of the fee schedule, it should be noted that, even in the interval during which the government unilaterally imposed a global revision of the Schedule of Benefits, (April, 1982) the relative values of tariff items were determined as a fixed proportion of those set out in the 1982 OMA Fee Schedule!

7.3.2 The Fee Structure

The purpose of this subsection is to provide some quantitative information on the structure of the fee schedule used by OHIP to assess and pay claims for services rendered by physicians on a fee-for-service basis. The full list of fees for the benefit package comprising all medically necessary services "which are not specifically excluded by legislation or regulation" (such as advice by telephone or acupuncture procedures) is contained in the Ontario Health Insurance Plan Schedule of Benefits, along with extensive "preambles" that provide working definitions. The 1981 version runs to about 240 pages and covers more than 2000 separate services or medical acts. 21b

As we have seen, the Schedule of Benefits is based on the Fee Schedule promulgated by the OMA. The basic structure had been developed in the 1940's and has changed remarkably little since then.

The structure can be perceived in the 5 digit alpha-numeric coding system that dates back to pre Medicare days and is still in use at the present. The prefix "A", "B" or "C" indicates a visit or consultation performed in respectively, the office, the home and in hospital on a non emergency in-patient basis, while an "H" prefix indicates hospital emergency or out-patient department services. While the first three letters of the alphabet were seized upon to describe the three most common locations for performing personal services, it seems that other letters of the alphabet were chosen initially for their intuitive recognition value: "L" for laboratory medicine; "X" for radiological services; "F" for fractures; "N" for surgical procedures on the nervous system, and so on. But there is

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obviously a limit to how much can be accomplished by this route, and it seems to have been reached with "E" for surgical procedures on organs of the special senses (eyes and ears).

The other diagnostic, therapeutic and surgical procedures are coded variously under other letters of the alphabet with no apparent pattern discernable.

The next two digits, for visit and consultation codes, originally designated specialty, but there are now many exceptions: "99" indicates a special visit premium for services other than regular office or hospital visits; "43" a limited consultation by a specialist, and so on. It was inevitable that the first two numeric digits would be thus invaded since only the third numeric is otherwise available to distinguish between all the different possible types of visits and consultations.

For procedures (diagnostic, therapeutic, surgical), all three digits are used to identify specific services. But medicine is a rapidly changing field, and technological change alone has led to a progressive proliferation of separate medical acts so that the reality being codified has long since outstripped the ability of a three digit code to describe it, and it has been found necessary to make use of the prefix to provide additional refinement of detail.

The suffix "A", "B" or "C" is used to distinguish between the performer of the service, the assistant, and the anaesthetist; or else, in the case of laboratory or radiological services, to indicate whether the claim is for both the professional and technical component of the procedure or for just one or the other.

The OHIP Schedule of Benefits is divided into 11 major practice categories:

1. Consultations and Visits
2. Nuclear Medicine
3. Therapeutic Radiology
4. Diagnostic Radiology
5. Clinical Procedures Associated with Diagnostic Radiological Examinations
6. Pulmonary Function Studies
7. Diagnostic Ultrasound
8. Diagnostic and Therapeutic Procedures
9. Obstetrics
10. Laboratory Medicine
11. Surgical Procedures.

Surgical procedures, in turn, are classified by the following hierarchy (which is also characteristic of the major medical procedural terminology systems used in the United States):

Major Category of anatomical system

Integumentary, Urogenital, etc.

Minor Category

Bones, fractures, etc.

Surgical Category

Incision, endoscopy, etc.

Individual Procedure

Anaesthesiologists and assistants at surgery are paid on the basis of time units. There is a specified number of units associated with each surgical procedure, and an additional allowance of one unit for each 15 minutes of time actually spent in either assisting or administering the anaesthetic.

No modifiers are used to designate variation in case severity. Instead, if a case is felt to be unusually simple, the physician can reduce the amount claimed and this lesser amount is then paid. There are no data on the extent to which this is done, and it is not thought to be extensive, but there is evidence that the practice of charging less than the OHIP benefit does exist. If the case is felt to be sufficiently complex or unusual, the physician can briefly state his reason when submitting his claim and request independent consideration. The claim will then be adjudicated by an OHIP medical consultant using, if possible, standards set out in medical payment policy bulletins issued by OHIP from time to time, and sent to all physicians registered with the Plan.

There are no geographic differentials in fees. Universal insurance and a single schedule of prices may provide subtle incentives to physicians to congregate in areas they find more pleasant or professionally interesting to the possible detriment of certain underserviced areas, and there is some evidence that this is the case in Ontario though the influence is so subtle that it cannot be assessed. Clearly, there are under-serviced areas in the province, especially in northern Ontario. It is not clear that the problem could be solved by having higher fees for those areas.

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Interestingly, we have seen that there has long been a concern that higher fees for specialists have encouraged a situation in which physicians have been attracted to the more interesting and prestigious specialties at the expense of general or family practice which many feel is under-manned. Despite this, there are still higher rates for specialists than for general practice for non surgical services, i.e., visits, radiology and anaesthesia, though recently differentials for surgical procedures have been eliminated. However, the elimination of the surgical differential was done at the same time that the major pre-operative visit fees were separated from the "surgical benefit" which formerly had included it along with the operative procedure, the post-operative care usually associated with the procedure, and any other necessary visits. Thus specialists do maintain a differential in that they have higher visit fees and are more likely to receive referrals which carry with them an even higher consultation fee. A major boost was given to general practitioners in 1978 when a new visit definition carrying a higher fee for some types of routine encounters was introduced.

In order to compare the relative fee structure in Ontario with fee structures in other jurisdictions, Tables 7-10 attempt to give OHIP Schedule of Benefit definitions of medical acts that correspond as closely as possible with a list of 50 of the more common medical acts, for which data on prevailing fees under the American Medicare program in various locations in the United States are assembled annually by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Since the definitions of medical acts in the Schedule of Benefits differ somewhat from the definitions in the American list, the tables are annotated by quoting extensively from the various preambles that form part of the schedule. The most difficult

TABLE 7

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - VISITS

PROCEDURE AND 64 CRVS CODE

PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

		General Code	Practice Fee	Internal Medicine Code	Internal Medicine Fee
1. Initial Limited Office Visit (9000) New Patient	Office Minor Assessment ⁽¹⁾	A001	9.45	A131	9.45
2. Initial Comprehensive Office Visits (9002) New Patient	Office Intermediate Assessment ⁽²⁾	A007	12.95	--	--
3. Minimal Office Visit -- Es- tablished Patient (9003)	Office General Assessment ⁽³⁾	A003	27.30	A133	37.80
4. Routine Followup Brief Office Visits (9004) Established Pa- tient	Office General Reassessment ⁽⁴⁾	A004	18.20	A134	27.30
	Office Specific Reassessment ⁽⁵⁾	--	--	A138	15.75
	Office Specific Assessment ⁽⁶⁾	--	--	A133	37.80
5. Routine Followup Brief Home Visit (9014)	Home Visit First Patient Assessment	B990	Add Special Visit Premium ⁽⁷⁾ \$8.40		
6. Initial Brief Hospital Visit (9020)	Hospital General Assessment ⁽⁸⁾	C003	27.30	C133	37.80
7. Initial Comprehensive Hospital Visit (9022)	Hospital General Reassessment	C004	18.20	C134	27.30
8. Routine Followup Brief Hospi- tal Visits (9024)	Hospital Subsequent Visits (Minor Assessments)				
	- up to 5 weeks (per visit)	C002	7.35	C132	8.75
	- 6th-13th week (Max. 3/wk)	C007	7.35	C137	8.75
	- after 13th week (Max. 6/month)	C009	7.35	C139	8.75

TABLE 7 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - VISITS (CONT'D)

FOOTNOTES

- (1) Minor Assessment: is a brief assessment comprising the necessary history, examination of the affected part or region, an appropriate record and advice to the patient. It also applies to a subsequent visit solely for assessing the response to treatment of a previously diagnosed condition when the necessary examination and/or assessment reveals that no additional clinical assessment is required and none is performed.
- (2) Intermediate Assessment: is a more extensive assessment than a minor assessment and shall comprise a history of the presenting complaint(s), enquiry concerning and examination of the affected part(s), region(s), or system(s) or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function, an appropriate record, and advice to the patient.
- (3) General Assessment: shall comprise a full history, an enquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient.

OHIP benefits for general assessments normally are limited to one per year per patient by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional general assessment may be claimed per year. In the case of a patient who proceeds normally to hospital, the admitting physician may claim one additional general assessment per year provided 90 days have elapsed since the last general assessment rendered (anywhere) to that patient by the admitting physician. If the patient doesn't qualify for a general assessment by the admitting physician, he may claim a general re-assessment.
- (4) General Re-Assessment: shall comprise the same services as a general assessment except that the history need not include all the detail already obtained in the original general assessment.

OHIP benefits for general re-assessments, except for hospital admission re-assessments, are limited to two per year, per patient, by any one physician.
- (5) Specific Assessment: shall comprise a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system, as needed to make a diagnosis and/or exclude disease and/or assess function, an appropriate record, and advice to the patient.

OHIP benefits for specific assessments normally are limited to one per year, per patient by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional specific assessment may be claimed per year.

TABLE 7. (continued)
COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - VISITS (CONT'D)

FOOTNOTES

- (6) Specific Re-assessment: shall comprise a full relevant history and a comprehensive physical examination of one or more systems but not requiring an evaluation of the patient as a whole.
- In the medical specialties, a specific re-assessment applies in the management and assessment of the progress of serious chronic disease. It is not to be claimed for treating a minor problem or for visits required solely for assessing the response to treatment of a previously diagnosed condition unless an additional clinical assessment is required and performed.
- (7) B990 is a special visit premium which is paid in addition to the regular office visit fee according to the rules governing special visits.
- A special visit is one which is initiated by the patient or his representative which requires a physician to travel from one location to another to see a patient(s). That is, when the physician is not already in the office, hospital, institution, patient's home, etc. and is called to make a special trip there to attend a patient, a "special visit" premium may be claimed. The premium(s) for a special visit to the office only applies outside of normal office hours but does apply whether or not the office is in the physician's home.
- (8) Definitions of hospital visits are the same as for office visits.

TABLE 8

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - SURGERY

PROCEDURE AND 64 CRVS CODE

PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

	Code	Procedure	(1) Assistant	(2) Surgery	(3) Anaesthesia
9. Biopsy Skin (0171)	9. Z116	Skin Biopsy(s) - any method - when sole procedure		8.40	
10. Radical Mastectomy	10. R109	Mastectomy, radical or modified radical (with or without biopsy)	5	280.20	6
11. Reduction of Fracture -- Neck of Femur (0868)	11.	Reduction of Fracture -- Neck of Femur			
	F098	Closed reduction	3	168.10	4
	F100	Open reduction	6	224.10	8
12. Arthrotomy -- Puncture for Aspiration of Joint effusion (1046)	12.	Bursae			
		Incision			
	Z225	Aspiration (I.O.P.)	-	10.50	-
	Z226	Drainage, abscess (I.O.P.)	-	29.40	4
13. Needle puncture of bursa (1413)	13. +G370	Injectations or infusions			
		Bursa joint or tendon sheath including preliminary aspiration	-	10.50	-
14. Bronchoscopy (2111)	14. Z327	Bronchoscopy			
		- with or without bronchial biopsy, suction or injection of contrast material	-	70.00	6
15. Thoracentesis (2183)	15. Z332	Thoracentesis (I.O.P.)			
		Aspiration with therapeutic drain- age with or without diagnostic sample	-	25.20	4
16. Catheterization of Heart (2330)	16. G293	Selective coronary catheterization - both arteries	-	133.10	5
17. Insertion of Pacemaker (2356)	17. R751	Implantation of epicardial elec- trode(s) plus implantation of pack	6	266.15	20
18. Blood Transfusion (2445)	18. G279	Indirect transfusion	-	10.50	-
19. Colectomy (3179)	19. S168 S169	Ileostomy, subtotal colectomy	7	462.30	7
		Total colectomy with ileo - rec- tal anastomosis	9	539.30	9
20. Appendectomy (3261)	20. S205 S206	Excision			
		Appendectomy	5	140.10	6
		- with gross perforation and peritonitis	5	199.60	6

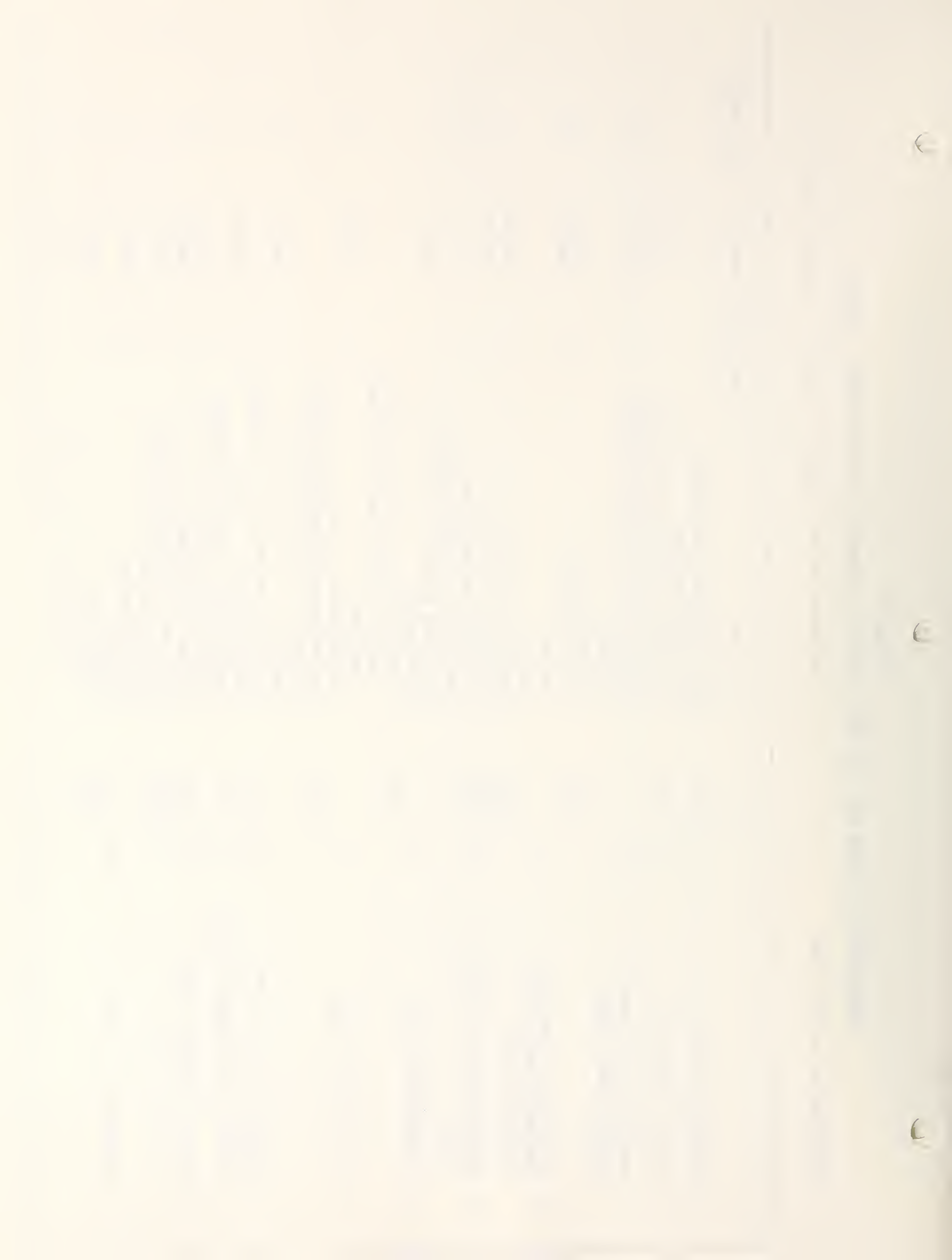


TABLE 8 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - SURGERY (CONT'D)

PROCEDURE AND 64 CRVS CODE

PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

	Code	Procedure	Assistant	Surgery	Anaesthesia
21. Sigmoidoscopy (3310)	21. Z535	Sigmoidoscopy (with rigid scope), with or without anoscopy	-	21.00	4
22. Hemorrhoidectomy (3380)	22. S247	Haemorrhoidectomy and/or sphincterotomy, with or without sigmoidoscopy or repair of fissure Note: Includes dilation/injection of anal sphincter and removal of anal polyp	3	126.10	4
23. Cholecystectomy (3515)	23. S287	Cholecystectomy	7	273.15	7
24. Repair Hernia (3531)	24.	Herniotomy Inguinal or femoral - single - Infants and children, with or without hydrocoele repair - Adolescents and adults	4 4	140.10 161.10	4 4
25. Cystoscopy (3930)	25. Z606	Diagnostic with or without urethroscopy (I.O.P.) (Panendoscopy)	-	39.90	4
26. Dilation of Urethra (4031)	26.	Dilation of stricture, male (Passage of Sounds) (I.O.P.) - local anaesthetic - general anaesthetic	- -	5.60 28.00	- 4
27. Prostatectomy (4316)	27. Z621 Z619	Prostatectomy (not to include investigative cystoscopy) but to include vasectomy when indicated	-		
	S645	Perineal	6	238.10	6
	S646	Perineal with vesiculectomy	8	360.70	11

Allowable Physician Charges for Selected Procedures
Across Various Insurance Plans

	(1) Rochester Blue Shield	(2) Conn Blue Shield	(3) Mass Blue Shield	(4) Equitable (Princeton)	(5) Western/St. Paul (L. A.) (Minn.)	(6) Boston (Boston)	(7) Calif., Blue Shield (North) (South)
90010 Initial Limited Office Visit			\$ 19.93	\$ 45.00	\$		47.00 45.00
90020 Initial Comprehensive Office Visit			46.49	80.00			103.00 105.00
90026 Extensive Consultation			66.42	150.00			135.00 155.00
93000 Electrocardiogram (EKG)	\$ 36.60	\$ 25.00	27.90	70.00			41.00 43.00
33205 Insertion of Pacemaker (Permanent Transvenous Electrode)	1,048.00	847.00	996.27	1,650.00	1,259.00	1,400.00	1,238.00 1,510.00
44140 Partial Colectomy	1,179.00	1,000.00	996.27	1,750.00	1,600.00	1,390.00	1,510.00 1,810.00
44900 Appendectomy	524.00	496.00	431.72	750.00	570.00	700.00	598.00 671.00
42840 Tonsillectomy Adenoidectomy (Under Age 12)	209.60	236.00	232.46	425.00	370.00	425.00	312.00 410.00
58150 Hysterectomy (Total)	786.00	779.00	797.01	1,200.00	965.00	1,200.00	1,260.00 1,510.00
46255 Hemorrhoidectomy (Internal & External)	393.00	320.00	398.51				560.00 660.00
66920 Extraction of Lens	943.20	1,000.00	876.72	1,500.00	1,320.00	1,500.00	1,360.00 1,510.00
49508 Hernia, Inguinal, Repair	524.00	450.00	411.79	750.00	585.00	660.00	685.00 810.00
59400 Full-Term Vaginal Delivery	497.80	472.00	597.76	900.00	600.00	800.00	975.00 1,025.00
71010 Chest X-Ray, Single View	30.00	23.60	26.57	45.00			38.00 39.00
43620 Gastrectomy (Total)	2,292.50	1,176.00	950.00				335.00 370.00
25604 Colles Fracture to Reduction							

(1), (2), (3), (6), Blue Shield Plans

(4), (5) Commercial carriers

SUMMARY OF BLUE SHIELD PLANS

BLUE SHIELD PLAN	PHYSICIAN PAYMENT METHOD	DETERMINATION OF FEES	FREQUENCY OF UPDATE	TERMINOLOGY SYSTEM	% POPULATION COVERED	% PHYS. PARTIC.
Rochester	Full-payment fee schedule based on relative values & conversion factors. Income ceiling for service benefit as of 1/1/82 is \$29,500. Beyond this ceiling, par. physicians can balance bill.	Relative values are decided by the physician advisory committee. Conversion factors are based on discounted physician fee components of the CPI. The Committee decides on an overall total sum of money for reimbursement. The physician in each category (surgery, radiology, etc) then decide on the allocation of monies among procedures; as well as whether to increase the fees on a procedure-by-procedure basis. Extra money is allocated for new procedures with consideration for the share allocation on the existing procedures.	Piece-meal RVS update every 2-3 years. Conversion to a common factor update every year.	Used CRVS up to '58. By now the RVS have evolved into a completely independent one from the CRVS.	85-90%	90%
Connecticut	Full-payment fee schedule with no income limit. Service benefit. Non-par. physicians paid by patients who are reimbursed by Blue Shield.	Fee profiles are studied to determine if and how much to increase. Fees are set high enough to ensure adequate physician participation, a ceiling of 16% increase on any single procedure. No overall percentile is used to determine allowable charges. Rather, choose a percentile for each procedure such that the resultant aggregate increase in cost is < that if the HCFA's physician fee inflation index was used.	Annually		33 1/3%	70%
Massachusetts	Full-payment, unbastardized, unpublished (hidden) fee schedule. Service benefit. Non-par physicians cannot get paid.	Using the UCR concept, but the increase in "customary" is limited to be < the Boston area urban wage earner (minus medical component) component of the CPI. For example, percentages increases on the customary level from 1978 to 1982 are: 4%, 0, 9%, 8.5%, 8%.	Annually	CRVS	60%	99%
California	UCR payment method. Service benefit. No balance billing by par. physicians.	UCR; 90th percentile.	Annually	CRVS	5% (7% by B/C No., 7% by B/C So: Hence, combined Blues share is 19%).	70%

TABLE 8 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - SURGERY (CONT'D)

PROCEDURE AND 64 CRVS CODE PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

	Code	Procedure	Assistant Surgery	Anaesthesia
28. Transurethral Electro- section of Prostate (434)	28.	Endoscopy (cystoscopy in- cluded)		
	S655	Transurethral resection of prostate (no additional benefit for cystoscopy, meatotomy, dilation of stricture, internal ure- throtomy or vasectomy when done at the same time)	-	266.15
29. Hysterectomy (4632)	29.	Hysterectomy (with or with- out adnexa)		5
	S757	Total - abdominal or vaginal	6	231.10
30. Extraction of Lens (5611)	30.	Cataract (includes iridectomy)		
	E140	- all types of by any procedure	4	262.65
	E141	- extraction of dislocated lens	4	262.65

TABLE 8 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - SURGERY (CONT'D)

FOOTNOTES

- (1) Assistants' Services: Benefits are determined by multiplying the listed units and time units by \$5.60. Time units are computed by allowing one unit for each 15 minutes or part thereof of time (up to two hours) spent by the assistant. Time units for assistants' services for periods in excess of two hours per case are computed by allowing two units for each 15 minutes or part thereof. Time for purposes of these calculations includes scrub time and time spent in the operating room. If claims are being made in coded form (see Preamble, part B, paragraph 14), the suffix B should be added to the code for the procedure.
- (2) The surgical benefit (except for fractures or dislocations requiring no reduction and other procedures either marked "I.O.P." (independent operative procedure) or including complete care) includes hospital visits rendered by the surgeon two days prior to surgery, the operative procedure, the post-operative care usually associated with the procedure(s) rendered by the surgeon while the patient is in hospital, and one office visit for follow-up examination, if necessary. If the surgeon is required to provide listed services not usually associated with the procedure(s), he may claim for these. If special visits to hospital are required and rendered, the surgeon may claim the appropriate special visit premium even if the basic hospital visits are not chargeable.
- The surgical benefit as noted above no longer includes the major pre-operative visit (e.g. consultation, general assessment, etc.) at which the decision to operate is made, regardless of the time interval between the major pre-operative visit and the surgery. The hospital or day-surgery admission assessment (consultation, repeat consultation, general assessment or re-assessment, specific assessment or re-assessment) may not be claimed by the surgeon unless it happens also to be the major pre-operative visit as defined above. Visits rendered prior to admission (excluding admission assessments) and hospital visits (minor assessments) rendered prior to two days before the surgery may be claimed in addition to the surgical benefit. For patients remaining in hospital because of complications, visit benefits may be claimed in addition to the surgical benefit after the second post-operative week. The starting point for calculating the appropriate number of hospital visits allowed in accordance with the Schedule after the second post-operative week is the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital.
- The listed surgical benefit includes the generally accepted surgical components of the procedure. The listed benefit of a procedure normally also includes any necessary repair of iatrogenic damage occurring during the course of the surgery.
- (3) Benefits for anaesthetists' services are determined by multiplying listed units and time units by \$6.37 for certified anaesthetists and \$5.88 for non-certified anaesthetists.

TABLE 9

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - RADIOLOGY

PROCEDURE AND 64 CRVS CODE

PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

		Technical (1)			Professional (2)		
		Special- ist	Special- ist	Non Special- ist	Special- ist	Non Special- ist	
		\$	\$	\$	\$	\$	\$
31. Chest X-ray (7100)	31. N.C. Miniature chest film - for survey purposes only X090 Single film	N.A.B.	N.A.B.	N.A.B.	N.A.B.	N.A.B.	(3)
	X091 Two views	9.80	7.35		3.30	2.45	
	X092 Three or more views	14.35	10.80		5.35	4.00	
32. X-ray Spine (7210)	X032 Entire spine - (scoliosis series) minimum of four views	18.40	13.80		6.40	4.80	
	X036 Pelvis and/or hips - one view	35.05	26.30		10.60	7.90	
33. X-ray Hip (7300)	X037 - two views (e.g. A.P. and frog view; both hips; A.P. both hips plus lateral one hip)	9.80	7.35		3.30	2.45	
	X038 - three or more views (e.g. pelvis and sacroiliac joints; A.P. both hips plus lateral each hip)	18.20	13.65		4.65	3.50	
34. X-ray Stomach (7356)	X108 Oesophagus, stomach and duo- denum (including survey film, if taken)	20.80	15.65		5.30	3.95	
	X104 Oesophagus, stomach and duo- denum (including survey film, if taken) - double contrast	30.30	22.80		15.40	11.60	
	X103 Oesophagus, stomach and duo- denum (including survey film, if taken) - double contrast, plus small bowel	31.60	23.70		16.90	12.70	
	X109 Oesophagus, stomach and small bowel	39.90	29.90		21.40	16.00	49.
		38.70	29.00		20.00	15.00	

TABLE 9 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - RADIOLOGY (CONT'D)

PROCEDURE AND 64 CRVS CODE

PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

		Technical		Professional	
		Special- ist	Non Special- ist	Special- ist	Non Special- ist
		\$	\$	\$	\$
35. X-ray Colon (7360)	35. X112 Colon - barium enema (including survey film, if taken)	31.60	23.70	14.00	10.50
	X113 Colon - air contrast, primary or secondary, in- cluding survey film, if taken	39.95	31.70	18.20	13.60
Teleradiotherapy is paid only to a certified therapeutic radiologist. The fee for all inpatient services is a hospital charge.					
36. Cobalt (7603)	36. } X301 Major treatment planning (150 KVP or higher), dosage calculation and preparation of any spec- ial treatment device			\$35.00	
37. Radio therapy - Super Voltages	X302 Teleradiotherapy - x-ray, 151 KVP or higher, radium, cobalt, cesium betatron linear accel- erator - charge per treatment visit				8.75
	X304 Minor teleradiotherapy - x-ray, 150 KVP or less- charge per treatment visit				5.95

TABLE 9 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - RADIOLOGY (CONT'D)

FOOTNOTES:

- (1) Technical - The benefit for radiological examination including the production of radiographs, supplying of contrast media, apparatus; premises, technical services, administration and collection costs.
- (2) Professional - The benefit for consultation between radiologist and referring physician, fluoroscopy, interpretation of radiographs and fluoroscopic findings and supervision of x-ray services by a radiologist.
- (3) Not a benefit

TABLE 10

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - LABORATORY MEDICINE AND DIAGNOSTIC PROCEDURES

PROCEDURE AND 64 CRVS CODE PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

		Laboratory Medicine Schedule	
		Units	Fees
38. Hemoglobin (8622)	38. L418 Hemoglobin	4	1.63
39. Blood, white cell count (8624)	39. L399 BWC count	4	1.63
40. Complete Blood Count (8628)	40. Complete Blood Count		
	L399 +	4	1.63
	L417 +	3	1.22
	L418	4	1.63
	Optional (L451 and/or L397)		
41. Cholesterol Blood Test (8652)	L451 Sedimentation rate	4	1.63
42. Hematocrit (8681)	L397 RBC count (Not manual method)	4	1.63
43. Prothrombin Time Test (8712)	41. L055 Cholesterol total	14	5.71
44. Sedimentation Rate (8718)	42. L417 Hematocrit	3	1.22
45. Blood Sugar (8722)	43. L460 Thrombin time	10	4.08
	44. L451 Sedimentation rate	4	1.63
	45. L111 Glucose quantitative (not by dipstick)	6	2.45
	L112 Glucose semi-quantitative (dipstick if read with reflectance meter)		
46. BUN--Urea Nitrogen (8745)	46. L251 BUN-Urea Nitrogen	3	1.22
47. Pap Test (8911)	47.+G365 Papanicolaou smear	6	2.45
	Note (No charge if done as part of a consultation, limited consultation, repeat consultation, general or specific assessment (or re-assessment), annual health examination or routine post-natal visit)		3.00
48. Urinalysis (8936)	48. L253 Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any or all of S.G., pH, protein, sugar, hemoglobin, ketones, urobilinogen, bilirubin)	7	2.86
	L254 Urinalysis, microscopy alone or one or more parts of L253 without microscopy (may not be claimed with urine culture for the same specimen)		1.22

TABLE 10 (continued)

COMPARISON OF 64 CRVS AND 1981 OHIP SCHEDULE OF BENEFITS RELATIVE FEES - LABORATORY MEDICINE AND
 PROCEDURE AND 64 CRVS CODE DIAGNOSTIC PROCEDURES (CONT'D)
 PROCEDURE AND OHIP SCHEDULE OF BENEFITS CODE AND FEE (1981)

Laboratory Medicine Schedule			Units	Fees
49. EKG (Electrocardiogram) (9101)	49.	Electrocardiography: (professional component must include pertinent written interpretation)		
	+G310	E.C.G. - technical component		4.55
	G313	- professional component - practice in general		4.20
	G318	- professional component - specialist		5.95
50. EEG (Electroencephalogram) (9330)	50.	Electroencephalography:		
	+G414	Technical component		12.25
	G415	Professional component		14.35
	G416	- with activating or sleep inducing drugs or sleep deprivation, add		
	Note	Use code G416 if claim states sleep recording but is not for overnight recording. Use G550 for overnight sleep recording.		9.80

area in which to make comparisons is that of visits since the Ontario schedule does not distinguish between new and established patients, deals with place of encounter in a different way, and places limitation on the number of visits to hospital in-patients based on length of stay in hospital. But even for many of the more standardized procedures, the Ontario fee schedule appears to be quite different from the major American medical procedural terminology systems, as can be seen in Table 11.

Table 11

Surgery of the Nose

Number of Procedures - Four Terminology Systems

<u>Surgical Category</u>	<u>Number of Coded Procedures</u>			
	<u>California Relative Value Studies</u>	<u>Current Procedural Terminology</u>	<u>Blue Shield</u>	<u>OHIP Schedule of Benefits</u>
Incision	2	2	3	2
Excision	12	12	7	20
Introduction	2	2	3	-
Removal of Foreign Body	3	3	-	2
Repair	15	14	15	3
Destruction	2	3	4	2
Other Procedures	6	6	-	7
Endoscopy	-	-	4	1
Manipulation	-	-	5	-
Total	42	42	41	37

Source: Department of Health Education and Welfare, Health Care Financing Research and Demonstration Series "Report No. 4: Medical Procedural Terminology Systems: Development and Characteristics of Three Major Systems for Third Party Payment" n.d. p. 75.

OHIP Schedule of Benefits April 1, 1981 pp. 155-6.

TABLE 12: Selected OHIP Schedule of Benefits Fees 1971 - 1981

	1971-73	1974	1975	1976	1977	1978	1979	1980	1981
GENERAL PRACTICE									
Minor Assessment - Office	5.40	6.03	6.30	6.75	7.20	7.35	7.70	8.30	9.45
Intermediate Assessment	13.50	13.95	14.40	15.30	16.65	17.50	19.50	11.50	12.95
General Assessment	8.10	10.80	10.80	12.60	13.50	14.00	14.65	22.90	27.30
Minor Assessment - Home	5.40	6.03	6.30	6.75	8.10	8.40	9.05	15.90	17.85
Well-Baby Visit	3.60	3.60	4.23	4.50	4.77	5.04	5.55	10.40	11.20
Hospital Visit During 1st 5 Weeks								6.40	7.35
Annual Health Examination	**	9.00	9.90	10.80	11.25	11.90	13.95	17.40	23.10
Allergy Injection G202	0.90	0.90	0.90	0.90	0.90	0.90	1.35	1.60	2.10
Tonsillectomy	31.50	31.50	31.50	45.00	45.00	45.50	48.80	75.10	100.80
Individual Psychotherapy	10.35	12.15	12.60	13.50	14.40	15.40	16.75	20.20	25.90
PAEDIATRICS									
Consultation	34.20	36.00	36.00	38.70	41.40	44.30	46.05	52.10	60.20
Well-Baby	7.20	7.33	8.10	8.55	9.00	9.00	9.05	10.40	11.20
PSYCHIATRY									
Consultation	34.20	36.00	37.80	41.40	44.10	46.20	50.90	54.90	63.00
Individual Psychotherapy	12.15	14.40	15.30	16.43	17.37	18.55	19.70	24.00	28.00
GENERAL SURGERY									
Consultation	18.00	19.30	20.70	22.50	24.30	25.20	25.20	27.80	32.90
Tonsillectomy	45.00	49.50	49.50	54.00	54.00	56.00	62.80	90.40	102.90
Appendectomy	90.00	97.20	99.00	112.50	112.50	119.00	132.55	149.50	173.00
Cholesystectomy	180.00	194.40	202.50	211.50	225.00	238.00	261.65	278.10	306.05
NEUROSURGERY									
Consultation	22.50	27.00	29.70	32.40	36.00	37.30	40.45	40.45	47.60
INTERNAL MEDICINE									
Consultation	34.20	36.00	37.80	41.40	44.10	46.20	50.90	54.90	63.00
Hospital Visit During 1st 5 Weeks	4.95	5.40	5.40	5.85	6.30	6.65	6.95	7.60	8.75
DERMATOLOGY									
Consultation	18.00	19.80	20.70	22.50	24.30	25.20	25.20	27.30	32.90
"UNITS"									
Laboratory Medicine (10 Units)		2.97	3.30	3.30	3.546	36.8	3.68	3.90	4.03
Assistant's fee units		3.33	3.60	3.87*	4.05*	4.20*	4.40*	4.37*	5.04*
Anaesthetist's fee (certified)		4.49	4.77	4.95*	5.04*	5.08*	5.27*	5.63*	5.73*

NOTE: The surgical benefit is standardized by including the fee for the major pre operative visit in 1980 and 1981

**Fee according to type of assessment

*There is a premium 6pm - 7am and holidays of 10% in 1976 and 30% thereafter

TABLE 13: Relative Values of Selected OHIP Schedule of Benefits Fees 1971 - 1981
(Minor assessment by a GP = 1)

	1971-73	1974	1975	1976	1977	1978	1979	1980	1981
GENERAL PRACTICE									
Minor Assessment - Office	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Intermediate Assessment						1.19	1.27	1.39	1.37
General Assessment	2.50	2.31	2.29	2.27	2.31	2.38	2.53	2.76	2.89
Minor Assessment - Home	1.50	1.79	1.71	1.87	1.83	1.90	1.90	1.92	1.39
Well-Baby Visit	1.00	1.00	1.00	1.00	1.13	1.14	1.18	1.25	1.19
Hospital Visit During 1st 5 Weeks	0.67	0.60	0.67	0.67	0.66	0.69	0.72	0.77	0.78
Annual Health Examination	*	1.49	1.57	1.60	1.56	1.62	1.81	2.10	2.44
Allergy Injection G202	0.17	0.15	0.14	0.13	0.13	0.12	0.18	0.19	0.22
Tonsillectomy	5.83	5.22	5.00	6.67	6.25	6.19	6.34	9.05	10.67
Individual Psychotherapy	1.92	2.01	2.00	2.00	2.00	2.10	2.13	2.43	2.74
PAEDIATRICS									
Consultation	6.33	5.97	5.71	5.73	5.75	6.10	5.93	6.28	6.37
Well-Baby	1.33	1.30	1.29	1.27	1.25	1.22	1.13	1.25	1.19
PSYCHIATRY									
Consultation	6.33	5.97	6.00	6.13	6.13	6.29	6.61	6.61	6.67
Individual Psychotherapy	2.25	2.39	2.43	2.43	2.41	2.52	2.56	2.89	2.93
GENERAL SURGERY									
Consultation	3.33	3.28	3.29	3.33	3.38	3.43	3.27	3.35	3.48
Tonsillectomy	8.33	8.21	7.86	8.00	7.50	7.62	8.16	10.89	10.89
Appendectomy	16.67	16.12	15.71	16.67	15.63	16.19	17.21	18.01	18.31
Cholesystectomy	33.33	32.24	32.14	31.33	31.25	32.38	33.93	33.51	32.39
NEUROSURGERY									
Consultation	4.17	4.48	4.71	4.80	5.00	5.14	5.25	4.87	5.04
INTERNAL MEDICINE									
Consultation	6.33	5.97	6.00	6.13	6.13	6.29	6.61	6.61	6.67
Hospital Visit During 1st 5 Weeks	0.92	0.90	0.86	0.87	0.88	0.90	0.90	0.92	0.93
DERMATOLOGY									
Consultation	3.33	3.28	3.29	3.33	3.33	3.43	3.27	3.35	3.48
"UNITS"									
Laboratory Medicine (10 Units)		0.49	0.52	0.49	0.49	0.50	0.48	0.47	0.43
Assistant's fee units		0.56	0.57	0.57	0.56	0.57	0.57	0.57	0.53
Anaesthetist's fee (certified)		0.71	0.76	0.73	0.70	0.69	0.68	0.68	0.61

See Notes Table 12

TABLE 14: Index of Fee Changes for Selected OHIP Benefits 1971 - 1981
(1971 = 100)

	1971-73	1974	1975	1976	1977	1978	1979	1980	1981
GENERAL PRACTICE									
Minor Assessment - Office	100.00	111.67	111.67	125.00	133.33	136.11	142.59	153.79	175.00
Intermediate Assessment									
General Assessment	100.00	103.33	106.67	113.33	123.33	129.63	144.44	169.63	202.22
Minor Assessment - Home	100.00	133.33	133.33	155.55	166.67	172.84	180.36	196.30	220.37
Well-Baby Visit	100.00	111.67	111.67	125.00	150.00	155.56	167.59	192.59	207.41
Hospital Visit During 1st 5 Weeks	100.00	100.00	117.50	125.00	132.50	140.00	154.17	177.78	204.17
Annual Health Examination									
Allergy Injection G202	100.00	100.00	100.00	100.00	100.00	100.00	150.00	238.41	320.00
Tonsillectomy	100.00	100.00	100.00	142.86	142.86	144.44	154.92	154.60	222.22
Individual Psychotherapy	100.00	117.39	121.74	130.43	139.13	148.79	161.34	195.17	259.24
PAEDIATRICS									
Consultation	100.00	105.26	105.26	113.16	121.05	130.99	134.65	152.34	176.02
Well-Baby	100.00	108.75	112.50	113.75	125.00	125.00	125.69	144.44	155.56
PSYCHIATRY									
Consultation	100.00	105.26	110.53	121.05	128.95	135.09	148.83	160.53	184.21
Individual Psychotherapy	100.00	113.52	125.93	135.23	142.96	152.67	162.14	197.53	230.45
GENERAL SURGERY									
Consultation	100.00	110.00	115.00	125.00	135.00	140.00	140.00	154.44	182.78
Tonsillectomy	100.00	110.00	110.00	120.00	120.00	124.44	139.56	200.89	228.67
Appendectomy	100.00	103.00	110.00	125.00	125.00	132.22	147.28	166.11	192.22
Cholecystectomy	100.00	112.50	117.50	125.00	132.22	145.36	145.36	154.50	170.00
NEUROSURGERY									
Consultation	100.00	120.00	132.00	144.00	160.00	163.00	179.78	179.78	211.56
INTERNAL MEDICINE									
Consultation	100.00	105.26	110.53	121.05	123.95	135.09	148.83	160.53	184.21
Hospital Visit During 1st 5 Weeks	100.00	109.09	109.09	118.18	127.27	134.34	140.40	153.54	176.77
DERMATOLOGY									
Consultation	100.00	110.00	115.00	115.00	125.00	135.00	140.00	154.44	182.78
"UNITS"									
Laboratory Medicine (10 Units)									
Assistant's fee units									
Anaesthetist's fee (certified)									

See notes Table 12

Looking at changes in the structure of the fee schedule over time, the overwhelming impression is that it has been incremental and gradual, evolutionary rather than revolutionary. Fees for a selected set of medical acts are shown in Tables 12-14. The observed gradualism is to be expected in view of the essentially political process involving the various sections representing different specialties within the OMA. And, for the same reason, it is also understandable that one, and only one, issue has dominated when questions of the relative values of fees have been debated. That issue has been the adequacy of the fee structure to distribute income "properly" across specialty groups, where "properness" has been determined by the relative bargaining power of the various interest groups.

We have already seen that the OMA explained adjustments in 1967 in terms of a continuation of the attempt (that had already been going on for some time) to improve the income of general practitioners. In the first "negotiated" fee schedule in 1974, on the initiative of the OMA, a "disparity formula" was used that defined three groups of specialties: an "underpaid" group; an "average" group; and an "overpaid" group. As Glaser concluded, "the formula in 1974 in Ontario was developed hesitantly: the range defining high and low fields and the halving of the deviation limited the scope. Only five specialties had their fees altered under the formula".²² In fact, the disparity formula was applied to only about one eighth of the 1974 global award of 7.75 per cent. The full distribution that year was as follows:

- to assure that each section had the same increase in its overhead factor, the percentage of gross income attributable to costs of

practice for each section was multiplied by 7.75%. This took approximately one-third of the increase.

- Next, the disparity factor was established for each specialty. If the average net income of a specialty was more than 10% over or under the mean for all specialties, half the difference between the net income and the 90-110% range was added or subtracted to the income. These two factors took 45% of the increase.
- The remaining amount was divided by the total number of physicians and multiplied by the number of physicians in each section. The sum of these three amounts was available to each section for fee adjustments.²³

Attempts to adjust "disparities" continued with each new version of the fee schedule since then with no basic structural changes occurring until 1978, but details of these adjustments are not publicly available. Throughout the period, general practitioners were given slightly higher than average increases in fees but this did not, apparently, sufficiently bring about the desired compression of the differential between their earnings and those of specialists. Accordingly in 1978, a new visit category, defining a level of service midway between the routine office visit, or minor assessment, and a comprehensive office visit, to be known as "intermediate" assessment, was introduced. Differential fees for specialists and general practitioners for surgical procedures were virtually eliminated in 1980, and the rules on special visits, more likely to be claimed by GP's than by specialists, were relaxed somewhat at the same time.

The reason, of course, that small incremented adjustments to fees did not have the desired effect on incomes is that the latter are a product of fee levels and utilization. An apt analogy would be that the size of a fee is like the size of a bucket used to dip water from a well. The amount of water that can be drawn out in a certain time (the life of a fee schedule) is certainly related to the size of the bucket, but the quantity is also related to the technique of weilding it. Anyone familiar with drawing water from a deep well knows that a bucket dangled on a rope frequently comes up only partly full because it failed to fully submerge. It does not require a great deal of imagination to conjure up technical improvements on a dangling bucket. As we shall see in the next section, there are reasons for believing that physicians have applied at least some thought to these technical matters.

4. The fourth part of the document discusses the consequences of failing to maintain accurate records. It states that individuals or organizations that fail to comply with the requirements may be subject to fines, penalties, and even criminal prosecution.

7.3.3 The Effect of the Fee Schedule on Medical Practice

The open-endedness of fee bargaining in the Ontario context in which prices are fixed but utilization is not has the potential to produce disastrous results. This was widely foreseen. For example, Malcolm Taylor, in a pioneering 1956 study of private health insurance in Canada, noted that no administrative agency could ever accept the situation, because it put the agency "practically in the position of a man with a fixed sum in the bank who has signed a blank cheque but who relies on others to fill in the amount".²⁴ The original terms of reference given to the Joint Committee on Physicians' Compensation in 1973 recognized that a "fee schedule is only a means", and that some control was ultimately needed on the product of prices and utilization if the public were going to be able to afford Medicare. Peter Ruderman, who served as the executive secretary to the first Joint Committee in 1974, was so impressed by the potential for disaster of the open-endedness of Ontario-style negotiations that he predicted that fee-for-service could not survive it, and indeed should be regarded, in the long run, as a transitional phenomenon that will eventually give way to other modes of remuneration.²⁵

Also, when physicians, in 1978, made representation to a Select Committee of the Ontario Legislature investigating health-care financing and costs claiming that public funding for physicians' services was inadequate and calling for user charges to supplement it, the Committee rejected the idea (because of the potential negative effects of such charges in inhibiting legitimate use of the health-care system by those who could not afford even moderate charges) and called instead for "a system of negotiating fees and

4. The fourth part of the document discusses the implications of the findings. It suggests that the results have significant implications for the field of study and may lead to further research in this area.

5. The fifth part of the document concludes the study. It summarizes the main findings and provides a final statement on the importance of the research.

utilization rates concurrently". This was based on the conclusion "that a policy of "cost containment" in the medical sector, which relies mainly on restricting the level of fees is unsound; it leads either to revolving-door practices with the concomitant dilution in the level of care, or to opting-out with the resulting transfer of costs (not containment) from the public to the private purse."²⁷

While the opportunity to use the fee schedule to influence medical practice has been recognized since the inception of Medicare, the institutional realities of fee bargaining have prevented such use. What there has been in Ontario instead, has been a process internal to the medical association in which limited and gradual adjustments have been made to average fee levels of the various specialties. As we shall see in the next section, failure to deal explicitly with the other half of the equation that produces physician incomes, namely, utilization, has led to a situation, deplored by physicians, called "revolving-door medicine". In other words, physicians, with varying individual success within specialties, and with varying collective success across specialties, have increased utilization by seeing more patients or providing more services per patient or by providing more expensive services. The extent of this utilization shift has not been trivial. The fact-finder in the latest Joint Committee negotiations (1982) has estimated that of the \$801 million increase in OHIP payments to fee-for-service physicians, (\$489 million in 1974-75 and \$1,290 million in 1981-82), \$425 million was the result of increases in the fee schedule while fully \$270 million was accounted for by increases in services per physician, the remaining \$106 million being accounted for by

growth in the physician stock. This is the situation that physicians in Ontario, over the history of fee bargaining with government, have, with evidently increasing frustration, come to call "revolving-door medicine".

Regrettably, data on utilization patterns in response to the financial incentives inherent in the fee schedule have not been closely studied

in Ontario. One reason for this is that there have been no dramatic attempts in Ontario to use the steering potential of the fee schedule to influence practice behaviour or to achieve other policy goals. Where there were attempts in other provinces to influence utilization by changing fees, reduction of the fee for "sclerosing injections of the lower extremities" in Quebec, for example, evaluation studies were undertaken. It is worth noting that those studies have been far from conclusive. About the only thing that can be said is that the response of
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physicians to fee changes is not uniform. In fact, some may expand their output significantly in response to a reduction in fees, presumably helped, in some cases, by referrals from those who cease performing the service. In the case of Ontario, studies of physician response to fee schedules are up against not only the problem of unravelling the complexity of the response, but also the problem that the stimulus is typically muted both in terms of its magnitude and in terms of the purposes that initiated it.

Instead, researchers in Ontario have noted that prices and utilization can substitute for each other and have focused on the problem of physician induced demand.

An empirical investigation of demand generation by Ontario physicians conducted by Wolfson in 1975 used billings data for all physicians bill-

1. The first part of the paper discusses the importance of the study and the objectives of the research. It also provides a brief overview of the methodology used in the study.

2. The second part of the paper presents the results of the study. It includes a detailed description of the data collected and the analysis performed. The results are presented in a clear and concise manner, using tables and figures where appropriate.

3. The third part of the paper discusses the implications of the study. It explores the potential applications of the findings and the limitations of the study. It also provides a brief overview of the conclusions drawn from the study.

4. The fourth part of the paper provides a summary of the study. It reiterates the main findings and the conclusions drawn from the study. It also provides a brief overview of the methodology used in the study.

5. The fifth part of the paper provides a conclusion. It summarizes the main findings and the conclusions drawn from the study. It also provides a brief overview of the methodology used in the study.

6. The sixth part of the paper provides a list of references. It includes a list of all the sources cited in the paper, including books, articles, and other documents.

7. The seventh part of the paper provides a list of appendices. It includes a list of all the supplementary materials provided with the paper, including tables, figures, and other documents.

ing OHIP in the period January - April 1974.³¹ This period was chosen because it was the first since the start of OHIP in which there was substantial increase in billings per physician. Within four months, billings per physician rose by an astonishing 10.6 per cent though there was a constant fee schedule and there was an absence of any identifiable change in exogenous demand. An analysis of the kinds of physicians whose billings grew fastest in this period and an identification of the individual services with highest growth rates was done to shed some light on the process of discretionary utilization generation.

To avoid the contaminating problems of entering or exiting physicians, a cohort of full-time fee-for-service practitioners active in both January and April was identified. (Parallel analyses were conducted using the entire physician population in either month with little change in the overall findings.)

Wolfson's results indicate that the high-growth specialties during this period were Therapeutic Radiology (15.4%), General Practice (13.8%), Plastic Surgery (13.1%), Pathology (12.6%), Paediatrics (11.5%), Dermatology (11.5%), Neurology (11.3%) and Internal Medicine (10.0%). The small number of practitioners in Therapeutic Radiology and Plastic Surgery may make those particular growth rates somewhat unreliable, but the other results are quite revealing. The Pathology figures reflect a hefty increase in lab tests ordered and thus are more likely to indicate the exercise of discretion by other physicians than demand generation by pathologists themselves. The high growth rates for general practice, paediatrics and medical specialties conform with intuitions about discretionary power.

At the other end of the scale, the surgical specialties, who on an "a priori" basis would be expected to enjoy less discretionary power than their medical counterparts, experienced relatively low rates of growth: Thoracic Surgery (-3.5%), Neurosurgery (-3.0%), Otolaryngology (3.2%), Obstetrics and Gynaecology (5.0%) and General Surgery (5.0%).

In terms of the types of services used in generating higher billings, the results are again revealing. Over one fifth of the entire increase in billings per physician is accounted for by a 10.7% growth in routine office visits. The highest growth rates were experienced in Annual Health Examinations (27.7%!) and Special Visits to Office, Outpatient Departments or Emergency Rooms for consultations (27.7%) and for Assessments (22.1%). Emergency visits while on hospital duty rose by 24.3%, and night, Sunday or holiday visits rose 21% in the office or hospital and 18% in the home.

What is not altogether clear from these results is the extent to which the increase in specific service categories indicates an actual change in the provision of services or simply a re-labelling of existing activities. Any accountant with experience in the medical field knows that the income potential from "strategic billing" is really quite impressive. Many physicians are not entirely "au courant" with the finer points of the fee schedule and during periods when there is pressure to increase billings (as in early 1974, after a year of devastating inflation) there may be a significant tendency to improve the sophistication with which services are classified and billed. Thus routine office visits may be converted to annual health examinations partly by the addition of real services (and presumably, time) and partly by the redefinition of current

servicing practices which were previously under-exploited in terms of the fee schedule. It is probable that some of the increase in various types of special visits and emergency services represents this kind of reclassification. This, of course, does not constitute fraud; it is simply a matter of efficiency in billing. This story does, of course, imply that physicians do not operate at maximal efficiency in relatively easy times from an income point of view, but that is not very hard to believe.

A survey of the research done on medical care across Canada by Evans and Wolfson in 1978 concluded in general:

Particular hypotheses about the provision of medical services consistent with the demand generation model (if not strictly derived from it) find considerable support in empirical studies of the workings of the Canadian system. Moreover, it is not simply the case that these are disjointed pieces of evidence relating to particular little stories, but that reinforcing findings from various parts of the country, often relating to the same hypothesis (e.g., the relative degree of discretionary power across specialties) provide integrated support for the theory.³²

And, on the basis of the evidence available to them, the authors came to the following specific conclusions:

1. Physicians quite clearly do have the power to shift the volume of services billed over a considerable range, despite a fixed fee schedule. The maximum rate of such shifting observed in Quebec, of 4% per physician per year over four years in the face of 6% annual increases in the physician/population ratio, represents large aggregate effects.

2. To some extent, these shifts represent relabelling of services for billing purposes rather than true generation of new services, the observed shifts from ordinary to complete examinations in Quebec (1971-76) and Saskatchewan (during the co-payment period) show this. But specific diagnostic and therapeutic services are also very amenable to expansion. Moreover, it should be noted that "complete examinations" or "psychiatric counselling" need not be solely relabelling of previous services. Insofar as, for fee schedule purposes, a longer visit is a different service from a shorter one, then increasing the availability of physicians and physician time leads to a real increase in servicing per patient.
3. Utilization generation is not general across items in the fee schedule; in particular, the problem of excessive surgery does not appear clearly tied to the economic incentives which encourage overservicing. Geographical variations in surgical rates are large, but despite economic pressures on physicians the incidence of major surgery does not appear to be rising (very much).
4. There are limitations on the rate at which physicians can expand utilization over time, so that the mechanism is not strong enough to secure income targets for physicians at all points in time. Practice styles seem to be costly to change (in non-monetary terms) so that variations for a given physician or group of physicians over time are much less than across physicians at a point in time. Apparently, there are many "right" ways to practise medicine, so that different physicians can make similar incomes from very different numbers of patients, but any individual physician shifts away from a concept of "right" practice only slowly and with discomfort. Tuohy and Wolfson's emulation effect relating "right" practice to what everyone else in the local area is doing undoubtedly retards shifts in practice style.
5. Utilization generation is quite a subtle phenomenon, which can occur by reallocation of fee schedule items among different practitioners. Depending on practice specialty and fee schedule structure, it can take the form of increases or decreases in the number of billings per practitioner. The true marginal cost of providing services is an important variable for the physician, and this may be difficult to establish and may vary across physicians for reasons quite apart from psychological costs of changing practice styles.³³

March 31, 1982, marked the end of the first decade of OHIP operation. It also marked the end of the illusion that the Government of Ontario - Ontario Medical Association Joint Committee on Physicians' Compensation was an effective, or even adequate institution for setting compensation for Ontario's fee-for-service physicians. On April 1, 1982, the Minister of Health "imposed" an immediate 11 per cent fee increase, with an additional 3 per cent on January 1, and further staged increases over the next two years, and the OMA began a series of "job-actions" that included temporary withdrawal of all but emergency services (on a rotating basis) across the province, refusal to serve on hospital committees, refusal to renew prescriptions by phone, and so on.

As the atmosphere became increasingly bitter, the doctors called a province-wide two day strike and threatened even longer strike actions. Finally, after the initial "job-action", a settlement was reached on May 1, 1982 on the basis of an agreement guaranteed for two years, extendable for another three years, if the OMA so chooses during the 60 days before April 1, 1984, when the second year of the agreement expires. The first year of the agreement is identical to the first year of the three-year deal imposed on April 1. Fees increased 11 per cent on April 1, and rise another 3 per cent after 9 months.

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37. "Ministers to consider cutbacks in enrolment at medical schools", Toronto Globe and Mail, October 2, 1980.
38. Wolfson, Tuohy and Shah (1978).
39. See, for example, "Ensure medicare or risk losing funds, Ontario told" Toronto Star, March 13, 1979.
40. On a business-case basis, OHIP has recently "simplified" the medical rules that it does apply to claims.
41. For a discussion of the use of pro-rationing in Ontario, see Taylor (1956) pp 148-151 and Glaser (1978) discusses some interesting variations on the theme in Europe, especially in West Germany, pp. 105-6.
42. Taylor (1956) p.150.
43. Taylor (1956) p.150.
44. Taylor (1956) pp. 151-2 describes the program in more detail.
45. See the May, 1973, Bulletin issued by the Medical Review Committee of the College of Physicians and Surgeons for the rationale used to explain the QSPF to physicians.
46. For a full discussion of this, see Tuohy, C. "Medical Politics after Medicare: the Ontario Case" Canadian Public Policy, 11:2, Spring, 1976. pp. 205-6.

In the second year, fees increase 8.75 per cent on April 1 (as opposed to the 8 per cent previously imposed) and 3 per cent on January 1. If the OMA renews the deal, fees will rise on April 1, 1984, by a negotiated amount that must be at least 7 per cent. In the fourth and fifth years, fees would rise by a negotiated amount in April each year and by another 4 per cent on January 1.

Both the Government and the OMA announced that they would be seeking a new system for determining regular increases for the future. The settlement appears to be most generous, given the prevailing depressed economic conditions and the large inflation - plus increases (4 per cent annually in years four and five). In its lead editorial, the influential Toronto Globe and Mail asserted that the Minister of Health had "wrestled the doctors to the ceiling".

What happened?

Accommodation 1969 - 1974

The initial honeymoon period of accommodation was fully understandable. The profession, on the one hand, moved with extreme caution because it was entering a new era in which changes were taking place affecting its most vital economic interests. The government, on the other hand, not only had other fish to fry, but they were bigger fish! Expenditures

on institutional care weremore than double those on ambulatory care, so the first priority was to control rapidly rising hospital costs. This was done by putting hospitals on constrained global budgets, limiting beds, and implementing a policy of rationalization of the institutional sector by providing less costly alternatives, such as, home care, where appropriate.

Meanwhile, physicians had not had an increase in fees since 1971, voluntarily postponed a fee increase in 1973 pending the findings of the Pickering Report which they had commissioned, and settled, in 1974, for a relatively modest two year agreement calling for a 7.75 per cent increase in fees in the first year and only 4 per cent in the second year. Under these circumstances, the problem of controlling expenditures on physician services was given relatively low priority by the government.

It is interesting to note that, in the first negotiations, one possibility that was considered and rejected, was that of abolishing the difference in fee levels between the OMA Fee Schedule and the OHIP Schedule of Benefits (which had been pro-rated at 90 per cent) rather than setting new OMA fees.³⁴ Physicians wanted to keep open the option of not participating in OHIP, even though the difference in suggested fees was only a nominal 10 per cent that would little more than cover the added expense of billing patients compared to billing a single agency that guaranteed payments, and even though the percentage of physicians opting-out was declining.

Another interesting feature of the early 1970's was that the government received some unsolicited aid in controlling utilization from physicians themselves. On their own initiative, the Medical Review Committee of the College of Physicians and Surgeons of Ontario (a special committee established under the Health Insurance Act with responsibility for reviewing referrals made to it by the General Manager of OHIP on grounds that services have been billed that were misrepresented, not medically necessary, inappropriate or simply not done at all), devised a formula, known as the Quality Service Payment Formula, which identified about 5 per cent of physicians' practices as being of sufficiently high volume as to call into question the quality of service being provided. The formula was proclaimed with maximum publicity in the spring of 1973.³⁵ While it was never used directly to reduce payments, the knowledge that the Medical Review Committee was opening files based on it caused great consternation among physicians who individually faced the threat of being reviewed by the Committee and having reimbursement reduced. It, undoubtedly, had some effect on practice behaviour. In fact, utilization, measured by billings per physician, in the 9 month period that the Formula was in operation, was practically flat. This is the only sustained period since OHIP began keeping records for which this is true.³⁶

Apparent Accommodation 1975 - 1977

The honeymoon was over in 1975 when physicians sought to re-negotiate that year's 4 per cent increase in the light of inflation; but the government refused and was subsequently aided by the federal government's

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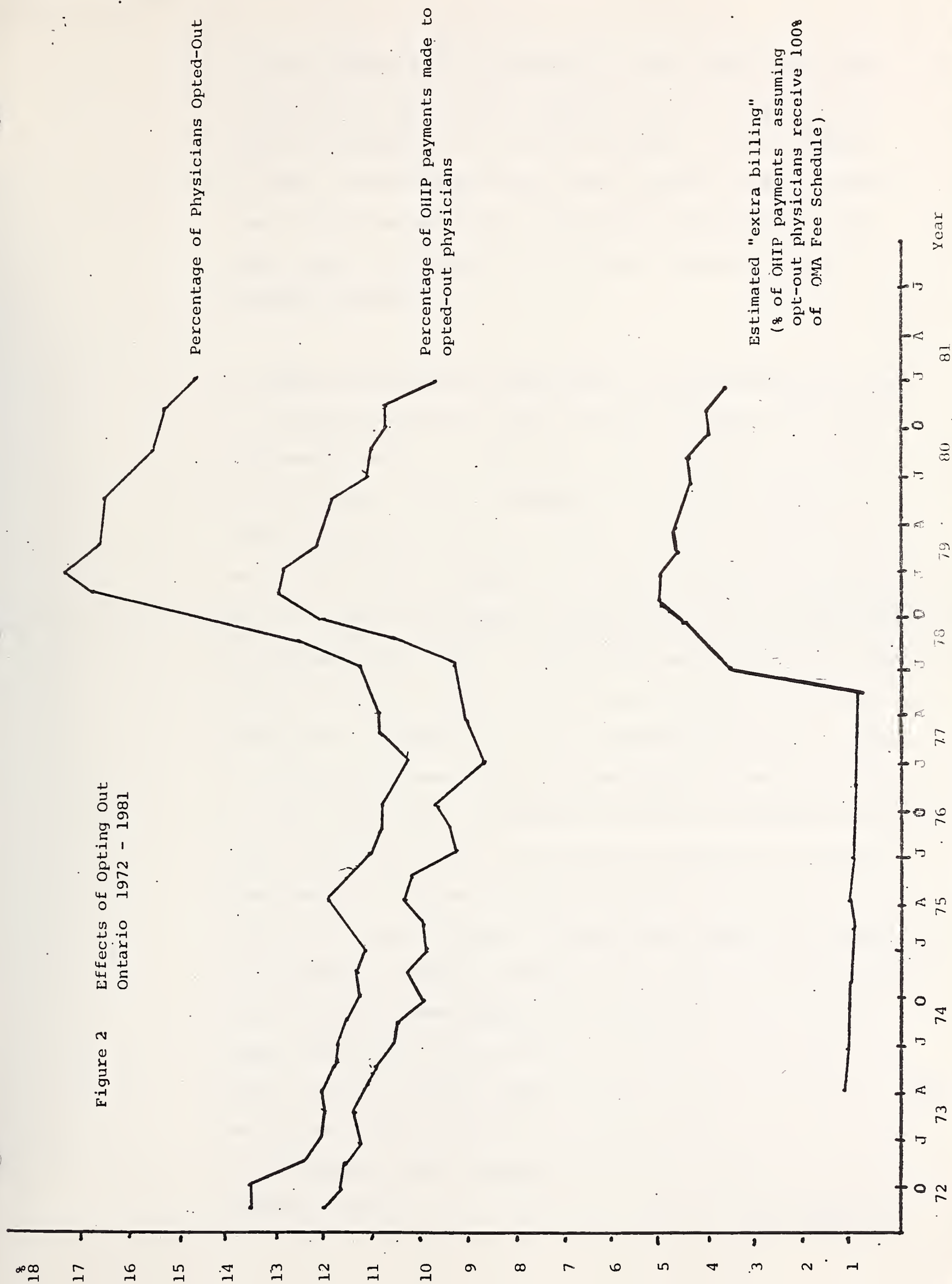
imposition of wage and price controls in October, 1975. Meanwhile, the federal and provincial governments with the endorsement of the profession, co-operated across Canada to virtually eliminate the immigration of foreign physicians into the country with a consequent reduction in utilization. This last action was the only explicit policy aimed at controlling utilization, (though not utilization per physician). A series of circumstances, most notably federal price controls, had conspired to put off the day when the utilization problem had to be addressed.

Latent Conflict 1978 - 1981

In the era of latent conflict, the utilization issue remained virtually dormant. The only exception during this time period was a meeting of provincial Health Ministers in September, 1980, to explore ways and means of reducing medical school enrolments across the country, and of preventing Canadians getting foreign medical training and returning to practise in Canada. This initiative, like immigration control earlier, was aimed directly at controlling utilization. To date, (1982), no policies have been implemented based on this initiative.

The physician strategy to avoid conflict took two forms. First, the OMA undertook a campaign to persuade the government to introduce user charges paid directly to physicians for all medical services. User charges were represented as a form of utilization control since it was alleged that a lack of cost-consciousness on the part of patients was responsible for excessive demand for services. This argument was carefully considered by the 1978 Select Committee of the Legislature investigating health care costs and financing. It was rejected on the grounds

Figure 2 Effects of Opting Out
Ontario 1972 - 1981



that user charges would not effectively reduce utilization though they might shift it from, say, the poor to the rich, as had happened in Saskatchewan in an earlier experiment with such charges. Of course, the additional private funds that would have been available to physicians would have eased somewhat the pressure on the public purse, but this was not a sufficient inducement to obtain government support.

The second tactic adopted by physicians was the double-barrelled one of unilaterally increasing fees in the OMA Fee Schedule well above OHIP benefit levels, and opting-out. But this tactic met with only partial success. Though the proportion of physicians opting out increased dramatically from 10.9 per cent in April, 1978 to 17.4 per cent in July, 1979, the proportion of OHIP billings that were "opted-out" (i.e. paid to subscribers for services received from physicians not participating in OHIP) was considerably less, rising in the same period from 9.2 per cent to 13.0 per cent, as a result the changes in regulations (discussed above) that increased opportunities available to opted-out physicians to bill for some patients on an opted-in basis. As Figure 2 shows, while the proportion opting out remained well above levels in the early 1970's, the proportion of payments to opted-out physicians has fallen back to about the lowest level ever at 9.7 per cent in July, 1981. Of course, assuming that opted-out physicians have been successful in receiving 100 per cent of the OMA Fee Schedule, the amount of private funds expressed as a percentage of OHIP payments jumped significantly from about 1.1 per cent of total payments for medical services in April, 1978 to a high of 5.2 per cent in April, 1979, and has been falling ever since to 3.9 per cent in July, 1981. Note that although no recent evidence is available on how much opted-out physicians actually collect from their patients, Wolfson et al found

that in the period before 1978, when the OMA Fee Schedule was only 10 per cent higher than the OHIP Schedule of Benefits, opted-out physicians on average charged about 18 per cent more than the OHIP rates.³⁸

Open Conflict 1982 -

The larger differential between the OMA and OHIP Schedules after 1978 suggests that relatively more private funding has been used to compensate physicians. This has led to widespread concern that one of the basic principles of Medicare - universal access on uniform terms and conditions - is being threatened, and the federal government has issued dire warnings that Ontario may lose federal funding if the situation goes too far.³⁹ It would seem that the limits of the opting-out strategy may have been reached. For physicians to make any further gains, given the competitive pressures of opted-out practice, it would be necessary to opt out en masse, and this sort of "tipping" phenomenon, which would effectively convert OHIP from a service benefit to an indemnity benefit plan, would not likely be politically acceptable.

On the government side, political and economic realities will ultimately require abandonment of the strategy for controlling expenditures for physicians' services of exclusive reliance on fee negotiations. Each year payments to fee-for-service physicians have increased at a rate significantly higher than fee increases. For example, the 14.75 per cent 1981 global fee increase resulted, taking account of increased utilization, in a staggering 19.2 per cent average income gain for full-time Ontario doctors, as compared with a 12.5 per cent increase in the Consumer Price Index.

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In Greek mythology, there is the story of Prokroustes, a robber who took his victims to his cave and lashed them to a bed, chopping them down to size if they were too large, and stretching them, if too short. In a sense, the Ontario government has been, and increasingly will be in the future, forced to make a Procrustean bed of total payments to fee-for-service physicians. Government negotiators, having no control over utilization, must hold the line on fee increases. In large part, the failure of the Joint Committee approach has been that it has gradually, over time, distorted the balance in the price times utilization equation that determines the size of total payments by holding down fee levels while letting utilization levels drift upwards. Forcing total fee-for-service payments to fit the Procrustean bed of available resources by controlling fees while utilization is unconstrained is seen (justifiably) by some physicians as, at the very least, unfair. There can be little doubt that all that has been accomplished by the present agreement is some breathing space. Both parties recognize that it must be used to establish a new basis for compensating physicians in Ontario.

Policy Options

If negotiated price increases are not an effective control on physician income, then the next step is to see what measures might be taken to foreclose some of the options by which physicians are circumventing the fee constraint.

We have already seen that in the context of Ontario, these measures might be taken by the government alone, or by some joint body such as the Joint Committee on Physicians' Compensation representing both the government and the profession. A further logical actor might be the profession, e.g., the OMA, acting alone. What must also be kept in mind is that Ontario is a part of a national Medicare scheme, and it is thus theoretically possible that initiatives might originate with the federal government. This chapter has been narrowly focused on Ontario. But the situation in Ontario is by no means unique and indeed there has been a great deal of parallelism in the development of Medicare across Canada, especially in English speaking provinces, but even to some extent in Quebec, which has had a quite distinctive historical development.

1) Direct Control of the Content and Standards of Practice

There are already a number of so-called "medical rules" which may be applied to reduce or disallow claims to OHIP. Some, such as, a limit of one appendectomy per person per life, or refusal to pay for hysterectomies performed on male patients, are eminently sensible on their face. Others may require more justification but are universally accepted as valid, such as, limitations on the number of health examinations that may be given. In theory, it is possible to extend these rules, but such a policy is unlikely to be effective in practice. Experience shows that even so defensible a rule, from the point of view

of good medical practice, as that against "male hysterectomies",
is not worthwhile applying from a business-case point of view.⁴⁰

The administrative cost of following up claims rejected by the rule, usually because of clerical error in the doctor's office or somewhere in the claims processing system, outweighs the saving. Even if elaborate, normative standards of practice were supplied by the profession (the probability of this occurring is infinitesimal) the attempt to regulate payments based on these standards would fail because of the administrative complexity of the task.

2) Application of a "Ceiling" Principle

An administratively simple method of assuring that claims on an insurance fund are constrained to a fixed amount is pro-rationing. If total submitted accounts total more than available funds, then each account is pro-rated and paid at an appropriate percentage. The "ceiling" principle is a device that has been quite widely used.⁴¹ It was an integral part of the physician-sponsored plans in Ontario that preceded Medicare and, for example, formed part of the participating physicians' explicit agreement with Physicians' Services Incorporated.

Despite its widespread use by physician-sponsored plans in Ontario, one observer of the system at the time found that it was only marginally acceptable because it created "the psychological impression on the physician that he is being underpaid, and this seems to hold true no matter how high his total income may be. The fact that he can make no rational defence

of the fee associated with any single item in a fee schedule in no way diminishes his reaction to what seems to him the imposition of 'bargain' rates".⁴² This attitude was found to be virtually universal among physicians all across Canada, and in addition, pro-rating of physicians' accounts in the government tax-supported social assistance medical care plans was found to be "a frequent source of irritation between official government agencies and the profession".⁴³

Explicit pro-rationing is not a solution to today's problem. In a general sense, the problem seems to be pro-rationing itself, whether or not it is done explicitly by agreement between government and participating physicians or implicitly by Joint Committee negotiation.

3) Alternate Modes of Remuneration

If the core of the dilemma in Ontario is 1) the incentive under fee-for-service, for each individual physician to attempt to maximize his income (by working harder/faster/longer than his colleagues) and 2) the inevitable relative devaluation of fees for medical acts that results, then one solution would be to institute alternatives to fee-for-service. To do so, would be a major break with tradition, and it is unlikely that such a dramatic change could take place by government fiat. But to the extent that there are disaffected physicians, who find themselves perpetually disadvantaged by the (fee-for-service) treadmill, an opportunity exists to encourage expansion of the small but solid base of individual and group practices that have persevered outside the fee-for-service system. A government policy of promoting alternative

payment arrangements and of removing legal barriers to the use of physician extenders might result in a significant increase in the proportion of Ontario physicians working outside the fee-for-service system.

4) Application of a Formula Approach

Another policy approach that deals directly with the core of the present dilemma, i.e., the speed-up of some physicians at the expense of others, is to apply criteria which identify who the "offenders" are. Fee-for-service is a form of piece-work remuneration. In any piece-work situation, a sort of cat-and-mouse game goes on between the worker and paying agency over the rate to be paid for each piece of work. In an assembly line situation, for example, this might take the form of workers changing the gearing on the machinery on the day the time-and-motion study is done so that they then have to perform at a frantic pace to produce an average output. And between rate reviews, piece-work operators are typically vigilant, lest isolated individuals, seeking to maximize their incomes, produce so much in a given time period that suspicion is cast on the rate being paid, and a new, more thorough evaluation of the job leads to a lower rate being set. This vigilance is usually exercised through informal peer group control. The "offender" who might be known by some such epithet as "rate buster" is approached in a "friendly" manner, say, by his peers who congratulate him on his productivity and give him a friendly little punch on the shoulder. If the rate buster has not gotten the hint after a few dozen "congratulatory" jabs, he is removed as a threat to the rates by being physically incapacitated! Of course, the assembly line metaphor

as applied to physicians' work is only partly applicable. However, there is ample evidence that peer group effects are a powerful influence over the way physicians conduct their practice of medicine. Two features of fee-for-service practice in the Ontario context vitiate the ability of the peer group to effectively control "rate busting". First, though some aspects of a physician's practice are open to observation by peers, especially services provided in hospital, much of what is done is not. The second factor may have been more important formerly than it is now. So long as the fund available to pay for fee-for-services claims was open-ended, and expanded to cover increased utilization without directly affecting rates, then "high rollers" (the expression used by Ontario doctors to describe those with high volume practices) were not perceived as "rate busters". However, even a government has limited resources and, as we have seen, the issue of meeting open-ended physician demands has become a major political issue. It is likely that a substantial number, if not the majority of physicians, are beginning to feel uneasy about their high rolling peers.

There are two models of the formula method to control utilization that have been used in Ontario, the difference between them being in their sponsorship. The first, the physician-sponsored formula approach, has a proven track record going back as far as the late 1930's. The second, the Medical Review Committee model, was tried out without success in the early years of Medicare.

In 1937, the Essex County (Ontario) Medical Relief Program devised a method of payment that identified high volume practices. A formula

which compared actual with expected number of services per physician based on the number of patients seen, average number of patients per physician, and the proportion of total visits represented by (a) office and (b) house calls, was applied, and after making an allowance for a physician's individual pattern of practice, some services by some physicians were identified as over-servicing and reductions were made in the reimbursements for these services.

It would seem that as long as the formula method of controlling utilization was practised by physician-sponsored plans, it was effective. At any rate, it continued to thrive and was still in use by Windsor Medical Services thirty years later when Medicare was introduced and apparently was practised in some form by a number of other plans as well, sometimes on as simplistic a basis as automatic reduction of payments exceeding county averages by a specified amount.

The Medical Review Committee model was seen by the Committee as an attempt to continue the tradition of the physician-sponsored formula method. The Quality Service Payment Formula was indeed explicitly modelled on the approach of an insurance plan operating in Essex County up to the introduction of Medicare, namely, Windsor Medical Services.⁴⁵

Throughout the latter part of 1973, while the QSPF was being applied, (though no actual adjustments to payments were being made), controversy within the profession raged. The debate was over the legitimacy of the Medical Review Committee using the formula method to control utilization. The main stumbling block was that the Committee was a government-created body charged with enforcing provisions of provincial legis-

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lation and in this respect, was (and is) regarded as different from
other Committees of the College of Physicians and Surgeons.⁴⁶ In the
end, the formula method, under quasi government sponsorship, was re-
jected as illegitimate by the profession and was abandoned. The
Medical Review Committee has subsequently confined itself to polic-
ing only the most extreme forms of abusive billings. Given the fact
that Medical Review Committee recommendations to OHIP for recoveries
have been frequently appealed to higher tribunals, and in some cases,
to the Supreme Court of Ontario, the impact of the Committee's utili-
zation review has been quite minimal. It should be noted that, to im-
prove the effectiveness of the utilization review that does occur, OHIP
has developed powerful econometric models of the supply of physicians'
services capable of standardizing for a large number of factors that
determine practice characteristics, and identifying physicians whose
actual practices are significantly deviant from what would be expected.

OHIP's new Physician Monitoring System represents a new level of
sophistication in the formula approach. Nevertheless, it is question-
able that even a more powerful analytic device would allow the govern-
ment to act effectively in constraining utilization increases. A
more promising future for the application of this system might be in
the context of the profession itself (in collaboration with government)
utilizing its capabilities to identify its own "rate busters".

To sum up, the outcome of the government's decade-long application of
a policy of exclusive reliance on fee negotiations to control expenditures
for physicians' services has resulted in a great deal of frustration a-
mong many physicians resulting from what are perceived to be inadequate
fee levels. At the same time, total payments to physicians have been

increasing at rates that are approaching the limits of political and economic acceptability. While the 1982 agreement will eliminate "the annual trauma of negotiations" for a few years, government and the OMA are on a collision course that requires a new basis for compensating physicians. Two policy options that have potential to control expenditures on physicians' services are: greater reliance on alternative modes of remuneration; and, application of a new formula method of reducing payments to physicians who over-service. To succeed, either policy would require a higher level of enthusiasm on the part of the profession than exists at the present. As far as the first policy is concerned, government-promoted initiatives might succeed in expanding, in a small way, the number of capitation contracts with, say, groups of family physicians. With respect to the second policy, the incentive to the profession to implement any form of utilization control is obviously determined by effective downward pressure on the real value of medical fees. Unfortunately, the three to five year deal on fees has the opposite effect.

APPENDIX - OHIP Benefits

a) Physicians services

- o physician's services in the home, the physician's office, the hospital or institution;
- o services of specialists certified by the Royal College of Physicians and Surgeons of Canada;
- o diagnosis and treatment of illness and injury;
- o treatment of fractures and dislocations;
- o surgery;
- o administration of anesthetics;
- o x-rays for diagnostic and treatment purposes;
- o obstetrical care, including prenatal and postnatal care;
- o laboratory services and clinical pathology, when ordered by and performed under the direction of a physician.

Until April 30, 1978, the Plan paid a maximum of 90 per cent of the fees listed for the above benefits in the Ontario Medical Association Schedule of Fees. From May 1, 1978, the Plan pays according to an OHIP Schedule of Benefits.

b) Hospital Services

For insured patients treated at an approved hospital by a licensed physician, the Plan covers the cost of the following hospital services, when medically necessary in the diagnosis and treatment of illness or injury, on an in-patient or out-patient basis:

- o standard-ward accommodation;
- o necessary nursing services, when provided by the hospital;
- o laboratory and x-ray diagnostic procedures;
- o drugs prescribed by a physician (except when the hospital visit is solely for the administration of drugs);

- o use of operating and delivery rooms, anesthetic and surgical supplies;
- o use of radiotherapy facilities;
- o services rendered by any person paid by the hospital.

In addition, Plan benefits are provided for the following services when prescribed by a physician as a medically necessary course of treatment and provided in Canada by hospitals approved by the Plan:

- o occupational therapy;
- o physiotherapy;
- o speech therapy;
- o out-patient diet counselling.

Physiotherapy is also covered in Ontario in private non-hospital facilities listed by the Plan when prescribed by a physician.

c) Extended Health Care

Where an insured person, who has been residing in Ontario for one year or longer, requires continuing nursing service and regular medical supervision in a participating nursing home or home for the aged, the Plan provides benefits toward the approved standard-ward costs of such care.. Eligible patients are required to pay a portion of the daily standard-ward costs.

d) Home Care

Certain patients whose physicians prescribe additional health-care services may be able to have these services provided in their homes. Such services could be needed instead of admission to hospital, or following early discharge from hospital. To be eligible for this bene-

fit, the patient must require limited care by a health professional on a home visiting basis. An insured person who qualifies for such home care through an organized Home Care Program in Ontario will not be charged for these services.

e) Ambulance Services

If the use of an ambulance is authorized as medically necessary, an insured person is required to pay only the following amount:

\$20 for a land ambulance trip.

\$20 for an authorized air ambulance trip (including the cost of connecting land ambulances).

f) Dental Care in Hospital

Dentists' fees, for a specified list of procedures, are covered up to 90 per cent of the Ontario Dental Association Schedule of Fees when:

- (a) performed in an operating room of an approved hospital; and
- (b) performed by a dental surgeon who is a member of the hospital's staff.

Hospital charges and anesthetist's fees for the above services are also covered.

g) Optometrists

Optometric services, when rendered by an optometrist, are insured benefits under the Plan. These services are paid at the approved fee rates. Most optometrists submit their accounts directly to the Plan for payment. An optometrist accepting payment directly from the Plan is not permitted to bill the patient any additional amount for this same service.

h) Other Health Services

For health services listed below, the Plan will provide benefits for essential care up to the maximum amounts indicated. (The dollar maximums apply to a 12-month period beginning July 1 each year and ending

June 30 of the following year.)

Chiropractors

Chiropractic services rendered in an office, institution or home - to a maximum of \$125 per person in total, including up to \$25 for related x-ray examinations.

Osteopaths

Osteopathic services rendered in an office, institution or home - to a maximum of \$100 per person plus up to \$25 for related x-ray examinations.

Chiropodists (podiatrists)

Chiropodist (podiatrist) services rendered in an office, institution or home (plus independent minor procedures as permitted under the statute) - to a maximum of \$100 per person plus up to \$25 for related x-ray examinations.

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32. Evans and Wolfson (1978) pp. 75-6.
33. Ibid pp.72-75.
34. Ruderman (1974)
35. College of Physicians and Surgeons of Ontario, Medical Review Committee Bulletin, May, 1973.
36. The phenomenon is discussed in Evans & Wolfson (1978)pp.48-49 and was analyzed by Wolfson (1977).



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